THE JOINT AIDS CASE MANAGEMENT PROTOCOLS (JACMP)

AIDS Case Management Program (CMP)
AIDS Medi-Cal Waiver Program (MCWP)

State of California
Department of Health Services
Office of AIDS
Community Based Care Section
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Section I: Introduction

Section II: Acronyms/Definitions

With the advent of complex medical therapies and the changing demographics of HIV transmission, persons living with symptomatic HIV Disease or AIDS have increasingly complex medical and psychosocial issues. HIV/AIDS continues to disproportionately affect women, people of color, and traditionally disenfranchised populations. The AIDS Case Management (CMP) and Medi-Cal Waiver Programs (MCWP) strive to promote 100% access to high quality health care and have 0% disparity in health outcomes for persons with HIV Disease or AIDS.

The CMP/MCWP utilizes an interdisciplinary team approach to case management, with each client being assigned both a nurse case manager (NCM) and social work case manager (SWCM). This model is used to ensure that a professional with the necessary specialized knowledge and expertise will address the client's complex needs. The CMP/MCWP can provide a number of services not available through other funding sources, in addition to case management in order to meet individual client goals.

Acronyms

ADAP	AIDS Drug Assistance Program
AIDS	Acquired Immune Deficiency Syndrome
ARF	Adult Residential Facility
CARE/HIPP	Comprehensive AIDS Resources Emergency Act/Health Insurance Premium Payment Program
CBC	Community Based Care Section
CCC	California Civil Code
CCS	California Children's Services
CDC	Centers for Disease Control and Prevention
CDSS	California Department of Social Services
CFA	Cognitive and Functional Ability Scale
CHHA	Certified Home Health Aide
CMP	AIDS Case Management Program
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CSP	Comprehensive Service Plan
DHHS	Department of Health and Human Services
DHS	Department of Health Services
DME	Durable Medical Equipment
DPOAH	Durable Power of Attorney for Health Care
DPOA	Durable Power of Attorney
EIP	Early Intervention Program
FTE	Full-time Equivalent
HCBS	Home and Community Based Services
HCO	Home Care Organization
HEA	Home Environment Assessment
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act

HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HPA	Health Program Advisor
HRSA	Health Resources and Services Administration
ICF	Intermediate Care Facility
IDTCC	Interdisciplinary Team Case Conference
IHSS	In-Home Supportive Services
LGA	Local Government Agency
MCWP	AIDS Medi-Cal Waiver Program
MMWR	Morbidity and Mortality Weekly Report
NCM	Nurse Case Manager
NF	Nursing Facility
NFLOC	Nursing Facility Level of Care
NOA	Notice of Action
OA/OOA	Office of AIDS
P&P	Policies and Procedures
PACE	Program of All-Inclusive Care for the Elderly
PD	Project Director
PIAR	Public Inquiry and Response Unit
PR	Progress Report
QA	Quality Assurance
QI/QM	Quality Improvement/Quality Management
RCFCI	Residential Care Facility for the Chronically Ill
RCFE	Residential Care Facility for the Elderly
RD	Registered Dietician
RFA	Request for Application
RFP	Request for Proposal
SDI	State Disability Insurance
SH	State Hearing

SHD	State Hearings Division
SOC	Share of Cost
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
SWCM	Social Work Case Manager
TA	Technical Assistance
TAR	Treatment Authorization Request
TCM	Targeted Case Management
TTD	Teletypewriter
URN	Unique Record Number

Definitions

Abuse, neglect, and exploitation refer to the physical, emotional, sexual or financial abuse, abandonment, isolation, neglect, or self-neglect of an individual. Please see *Section VIII, Risk Assessment and Mitigation* in these Protocols for information on identifying these types of instances.

Adult refers to an individual who is thirteen years of age or older.

AIDS is Acquired Immunodeficiency Syndrome, as defined by the Centers for Disease Control and Prevention.

Attending Physician is a person licensed as a physician by the Medical Board of California or the Board of Osteopathic Examiners and identified by the client and physician as having the most significant role in the determination and delivery of the client's HIV-related medical care. This may be either the client's primary care physician or a specialist primarily responsible for treating the client's HIV Disease or AIDS.

Benefits Counselor is a person who may assist the nurse case manager or social work case manager by providing referrals and information about a client's eligibility for benefits and entitlements. There are no minimum qualifications for the benefits counselor, but knowledge of a community's service resources for persons with HIV Disease or AIDS and of eligibility for government programs is desirable.

Case Aide is a person who may assist the nurse case manager or social work case manager with practical arrangements for meeting service needs. There are no minimum qualifications for the case aide, but knowledge of a community's service resources for persons with HIV Disease or AIDS and of eligibility for government programs/benefits is required. Functions a case aide may perform include financial assessment/reassessment, home environment assessment/reassessment, resource evaluation, transportation, delivering vouchers, assisting with benefits counseling and referrals, and advocating for the client and client resources. A case aide may not perform nursing or psychosocial assessments or reassessments, or the development of the initial service plan. A case aide may perform home environment and financial assessments and reassessments.

Case Management is the process through which a nurse case manager and social work case manager coordinate a core case management team to accomplish the functions of initial and ongoing client assessment; development, implementation and evaluation of a service plan; and the location, coordination and monitoring of cost-effective, quality services provided in accordance with the client's needs as set forth in a comprehensive service plan. Case Management incorporates a collaborative, interdisciplinary team approach. Case Management includes: (1) client eligibility and

identification; (2) comprehensive client assessment and reassessment; (3) resource identification and service planning; (4) service delivery; and (5) evaluation. The nurse case manager and social work case manager both perform the functions of case management, as identified in the service plan.

CDC Classification System for HIV Infection in Children Under 13 Years of Age classifies children by asymptomatic or symptomatic (N, A, B, or C) and immunologic categories (1, 2, or 3). (MMWR September 30, 1994/ Vol.43/No.RR-12) The instrument establishes criteria for classifying a pediatric (under 13 years of age) client's HIV status.

Cognitive and Functional Ability Scale (CFA) is a revised form of the Karnofsky Performance Status Scale and was developed to correspond with the Karnofsky Scale. The CFA Scale was developed to include factors affecting cognitive and functional ability that are specific for adults with HIV infection. It is used to determine eligibility for the CMP and MCWP and both the NCM and SWCM must have input in determining an appropriate score.

Comprehensive Service Plan is a client-oriented written document that identifies a client's problems and needs, services (interventions) the client will receive, and expected results in measurable terms, with short-range and long-range goals.

Contractor is the entity that has entered into a contract with the Department to provide case management services under these programs to eligible persons with HIV Disease or AIDS with current symptoms related to HIV Disease, HIV Disease treatment or AIDS.

Core Case Management Team consists of the nurse case manager, the social work case manager, case aides, and benefits counselors (if applicable) who work in the CMP and/or MCWP.

Cost Avoidance is the process used to ensure that all available resources are screened for and accessed prior to the utilization of CMP and MCWP funds. Cost avoidance activities can take one of two forms. First is the use of any private insurance or fee-for-service Medi-Cal, the use of the TAR (treatment authorization request) system, and other available resources. Second is the screening and access of other local community resources to pay for services such as food, housing, transportation, and utilities prior to utilizing program funds. Cost avoidance is not a routine part of assessment or reassessment activities.

Department is the State of California Department of Health Services, Office of AIDS, Community Based Care Section.

Exemption is a written request from a Contractor, approved in writing by the Department, for a temporary suspension or modification of program requirements or contract language. An exemption may be requested for staff qualifications, staff-to-client ratios, subcontracting for key case management staff, provision of direct care services, and augmentation of CMP service rates with other funds (CMP only). Exemptions must have prior approval by the Department. Contractors should not make a hiring commitment or begin using the alternative standard until written approval is received.

Family includes persons related to each other, sharing the same household, or mutually identifying themselves as such.

Foster Child is any child under the age of 18 (unless otherwise specified) who qualifies as a recipient of foster care pursuant to Sections 300 et.seq., 11251, and 11400 et.seq., of the Welfare and Institutions Code.

Health Program Advisor (HPA) is the Department staff person assigned to a CMP/MCWP Contractor as the primary contract manager and key contact person. The HPA provides technical assistance to assure that the Contractor carries out the requirements of the agreement between the Department and the Contractor. The HPA is also a liaison between the Department and other state programs as necessary. HPA's conduct program compliance reviews, develop and evaluate programs, negotiate budgets and track program expenditures, evaluate and approve exemption requests, research and respond to various program issues, and assist in developing policies and procedures.

HIV is Human Immunodeficiency Virus.

HIV Disease is a medical diagnosis of HIV infection ("HIV positive"), including diagnoses of Asymptomatic HIV and Symptomatic HIV Disease. A person who has Asymptomatic HIV is not eligible for the CMP or MCWP, except for pediatric clients under 18 months of age who may be enrolled in the CMP. Please refer to the *CDC Classification System for HIV in Children Under 13 Years of Age form (CMP/MCWP 6), Page 2, Diagnosis: Seroreverter (SR)*.

Level of Care is a description of the care and supervision needs of an individual, based on the assessed deficits and abilities. The Nursing Facility Level of Care (NFLOC) or higher (sub-acute or acute care hospitalization) must be determined for enrollment into the MCWP.

Mandated Reporter is a person who has assumed full or intermittent responsibility for the care or custody of and individual, whether or not they are compensated for their services. For a complete list of who is a mandated reporter of elder and dependent adult abuse, refer to the California Welfare and Institution Code, Section 15630 (a), Section 15610.17, and Section 15610.37. For a complete list of who is a mandated reporter of child abuse, refer to the California Penal Code, Section 11165.7. The following link will assist in accessing these codes: http://www.leginfo.ca.gov/calaw.html.

Nurse Case Manager is a Registered Nurse (RN) licensed by the State of California who has two years experience as an RN, with at least one year in community nursing. It is desirable, but not mandatory, that the RN Case Manager has obtained a Bachelor of Science degree in Nursing (BSN), and has a Public Health Nurse certificate (PHN).

Nursing Facility Level of Care (NFLOC) is defined in Title 22, California Code of Regulations, sections 51334 and 51335. Briefly, the regulations state that a patient qualifies for Nursing Facility services if he/she has a medical condition which requires an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing basis to abate health deterioration. Guidelines for determining the NFLOC are included in Section X of this document. The NFLOC is a combination of the previous Intermediate Care Facility (ICF) and Nursing Facility (NF) Levels of Care.

Pediatric refers to two categories of individuals, (1) those who are under eighteen months of age and (2) those who are eighteen months of age to under thirteen years of age.

Primary Care Practitioner may be a physician licensed by the Medical Board of California or the Board of Osteopathic Examiners; an individual licensed as a Registered Nurse with a certificate to practice as a Nurse Practitioner from the California Board of Registered Nursing; or a Physician Assistant licensed by the California Physician Assistants Examining Committee of the Medical Board of California. The primary care practitioner is identified by the client and provider as having the most significant role in the determination and delivery of the client's HIV/AIDS-related medical care.

Project Director (PD) is an individual designated by the contractor to provide oversight to all CMP and/or MCWP contract activities. The PD has the overall responsibility for assuring compliance with the terms of the contracts and serves as the primary representative of the Contractor. The Contractor shall notify the Department immediately in writing when a new Project Director is designated. The Project Director is subject to Department approval. Educational and experience requirements are at least a Masters Degree in a health related field plus one (1) year management experience or a Bachelor's of Arts or Science Degree in a health related field and at least three (3) years of experience in a management position in the health care field.

With prior written approval by the Department, other experience may be substituted for educational requirements (for clarification as to what constitutes a health related field, please consult the Department). Knowledge of the interdisciplinary case management model of home and community based care is desirable.

Psychotherapist is (1) an individual licensed by the State of California as a Licensed Clinical Social Worker (LCSW) or a Clinical Psychologist; an individual licensed as a Marriage and Family Therapist (MFT); or a nurse with a Master's Degree designated as a Psychiatric and Mental Health Clinical Nurse Specialist or a Psychiatric and Mental Health Nurse Practitioner; or (2) an individual with a Master's Degree in Social Work (MSW) who is license eligible (registered as an Associate Clinical Social Worker (ACSW) with the State of California Board of Behavioral Sciences Examiners; an individual with a Master's Degree in Clinical Psychology or Counseling Psychology who is license eligible (registered with the Board of Behavioral Sciences Examiners). For those individuals in (2) above, supervision must be provided by the appropriately licensed individual as approved by the Board of Behavioral Sciences Examiners. The Psychotherapist may provide ongoing therapy to clients with regard to the psychological adjustment to living with HIV/AIDS. The Psychotherapist may also provide therapy to caregivers of clients with end-stage AIDS. This service may be provided with or without the client present. Services may also include information and referral, as well as group and family therapy with the client. The Psychotherapist does not perform any case management activities under the CMP and MCWP.

Quality Improvement/Quality Management (QI/QM) refers to the ongoing assessment, monitoring, and evaluation of client-related activities in a profile of cases. QI/QM involves critical evaluation of the Contractor's operational structure and processes involved with the provision of services and client outcomes. The goal of the QI/QM Program is the improvement of client outcomes.

Risk Assessment and Mitigation is the process of identifying potential health and welfare risks to clients with the goal of reducing the likelihood of occurrence or recurrence of situations or events.

Share of Cost (SOC) is the amount of money a Medi-Cal recipient has to pay or agrees to pay each month for medical goods and services before Medi-Cal begins to pay. Once the share of cost is met, Medi-Cal pays for goods and services the rest of the month.

Social Work Case Manager is an individual licensed by the State of California as an LCSW, MFT, or Psychologist; an individual who has a Masters Degree in Social Work, Counseling, or Psychology; or an individual with similar qualifications approved by the Department. The social work case manager serves as a member of the core case management team and provides case management services. The social work case manager does <u>not</u> perform the functions of the Psychotherapist.

Subcontract is an agreement entered into by the Contractor with any provider who agrees to furnish services to clients or agrees to perform any administrative or service function to fulfill the Contractor's obligation to the Department under the terms of the agreement.

Symptomatic HIV Disease describes a variety of symptoms found in some persons infected with HIV. These may include recurrent fevers, unexplained weight loss, swollen lymph nodes, fatigue, and persistent diarrhea. For CMP and MCWP eligibility, "symptomatic" can refer to symptoms related to HIV Disease, HIV Disease treatment, or AIDS.

Targeted Case Management consists of case management services that assist Medi-Cal eligible individuals within specified targeted groups to access needed medical, social, educational, and other services. TCM service components include needs assessment, setting needs objectives, individual services planning, service scheduling, crisis assistance planning, and periodic evaluation of service effectiveness. LGAs that participate in and claim through the TCM program and other programs providing case management sevices must include in their Performance Monitoring Plans a description of the systematic controls that ensure no-duplication of TCM services.

A. Goals

The goals of the CMP and MCWP are:

1. The provision of appropriate services for persons diagnosed with HIV Disease or AIDS with current symptoms related to HIV Disease, HIV Disease treatment, or AIDS;

2. To assist clients with disease management, preventing disease transmission, stabilizing their health, improving their quality of life, and avoiding costly institutional care;

3. To think of enrollment in the programs as time limited. As a client's medical and psychosocial status improves, the client should be assisted in transitioning to more appropriate programs and services, freeing valuable CMP/MCWP resources for people who are most in need;

4. To foster resource development;

5. To increase coordination among service providers;

6. To eliminate service duplication;

7. To enhance utilization of the program by underserved populations; and,

8. To provide home- and community-based services for persons with disabilities who would otherwise require institutional services (the 1999 Supreme Court decision, Olmstead, resulted in an important legal ruling that individuals with disabilities should live in the most integrated setting appropriate to their needs).

B. Objectives

The objectives of case management within the CMP/MCWP are:

1. To coordinate the efficient use of community resources in a cost-effective, high quality manner acceptable to the client;

2. To foster continuity of services throughout the continuum of care;

3. To promote understanding by the client, family, and the client's representative of the HIV Disease or AIDS process and the use of health promotion practices;

4. To decrease the transmission of HIV through education/harm reduction techniques;

5. To assist the client, family, and the client's representative in moving toward self-determination;

6. To maintain quality healthcare along the continuum of illness;

7. To decrease fragmentation of care;

8. To promote the provision of quality care in the least restrictive environment;

9. To establish and maintain linkages with community agencies and institutions; and,

10. To provide services through culturally and linguistically appropriate service networks.

The above objectives are achieved through an organized, collaborative model of case management in which each member of the interdisciplinary team has responsibility for service activities in his or her area of expertise.

C. Functions

The functions of case management in the interdisciplinary model include, but are not limited to:

1. Community outreach to expand the client base; specifically, to reach populations and/or groups in the community disproportionately affected by HIV/AIDS;

2. Assess eligibility and assist with institutional discharge planning to ensure the transition of qualified individuals into the CMP/MCWP;

3. Eligibility screening to identify appropriate clients for intake and case management;

4. Comprehensive assessment of the client's physical, psychosocial, environmental, financial, and functional status. Identification and proposed resolution of problems in the utilization and delivery of client services and any special client preferences and desires regarding service providers;

5. Assessment of informal (family and friends) and formal (community and institutional) support systems;

6. Development, implementation, monitoring, and modification of a comprehensive individual service plan through an interdisciplinary team process in conjunction with the client and his/her caregivers;

7. Coordination of the provision of services to the client including but not limited to: in-home skilled nursing care, in-home attendant care, homemaker services, nutritional counseling and supplements, psychotherapy, durable medical equipment, housing assistance, food subsidies, and transportation;

8. Reassessment of the client's physical, psychosocial, financial, and functional status at regular intervals and as needed;

9. Evaluation of the service plan and specific services through reassessments and case conferences;

10. Transition to less intensive case management services when health and functional status improves and stabilizes; and,

11. Linking the client with the most appropriate resources and advocating for the best interests of the client.

A. MCWP Eligibility

Each MCWP client must meet all of the following criteria:

1. Be Medi-Cal eligible and a recipient on the date of enrollment. The Medi-Cal Aid Code must have: 1) federal financial participation, and 2) full benefits, excluding those in Long Term Care or those who are restricted (e.g. restricted to emergency room only or pregnancy only); Note: a client may be dually enrolled in Medi-Cal Managed Care Plans except the PACE (Program of All-inclusive Care for the Elderly) Program;

2. Have a written diagnosis from his/her attending physician of HIV Disease or AIDS with current symptoms related to HIV Disease, HIV Disease treatment, or AIDS. For adults 13 years of age and over this is documented on the MCWP Certification of Eligibility – Physician form (MCWP 2). For pediatric clients under 13 years of age this is documented on the CDC Classification System for HIV in Children Under 13 Years of Age form (CMP/MCWP 6).

3. Not be simultaneously enrolled in CMP;

4. Not be simultaneously enrolled in the Medi-Cal Hospice Program or other Medi-Cal Waiver Program (may be simultaneously enrolled in Medicare Hospice);

5. Must not simultaneously receive case management services or use State Targeted Case Management Program funds to supplement MCWP;

6. Be certified to meet the NFLOC as described in Title 22, California Code of Regulations, Sections 51134-51135;

7. Adults 13 years and older must have a CFA score of 60 or less. Pediatric clients under 13 years of age do not require a CFA score at this time.

8. Have an attending physician willing to accept full professional responsibility for his/her medical care;

9. Have a health status that is consistent with in-home services; and,

10. Have a home setting that is safe for both the client and the service providers.

B. CMP Eligibility

Each CMP client must meet all of the following criteria:

1. For adults, have a written diagnosis from his/her attending physician/primary care practitioner of HIV Disease or AIDS. This is documented on the CMP Certification of Eligibility – Physician/Primary Care Practitioner form (CMP 2). The NCM must certify current symptoms related to HIV Disease, HIV Disease treatment, or AIDS.

   For pediatrics, must have a written diagnosis from his/her attending physician/primary care practitioner of HIV Disease or AIDS with current symptoms related to HIV Disease, HIV Disease treatment, or AIDS. This is documented on the CDC Classification System for HIV in Children Under 13 Years of Age form (CMP/MCWP 6). The physician/primary care practitioner must certify current symptoms related to HIV Disease, HIV Disease treatment, or AIDS.

2. Not be simultaneously enrolled in the MCWP;

3. Adults 13 years of age and older must have a CFA score of 70 or less. Contractors may elect to provide services to clients with a CFA score greater than 70 for a period of up to six months (this does not require an exemption or notification to the Department). This extended need for intensive case management services must be well documented in the client record and will be reviewed during program compliance reviews to assure compliance.

   Pediatric clients under 13 years of age do not require a CFA score at this time.

4. Have a physician/primary care practitioner willing to accept full professional responsibility for his/her medical care;

5. Have a health status that is consistent with in-home services; and,

6. Have a home setting that is safe for both the client and the service providers.

The following table will assist you in determining which documents are required when certifying client eligibility:

	CMP			MCWP	
Document	**Under 18 Months**	**18 Months to Under 13 Years of Age**	**13 Years of Age and Over**	**Under 13 Years of Age**	**13 Years of Age and Over**
CDC Classification System for HIV in Children Under 13 Years of Age	Yes *Asymptomatic or Symptomatic (may also be HIV negative)*	Yes *Symptomatic*	No	Yes *Symptomatic*	No
Cognitive and Functional Ability (CFA) Scale	No	No	Yes	No	Yes
Certification of Eligibility (COE)	No	No	Yes	No	Yes

C. MCWP Enrollment and Disenrollment Process

1. Enrollment Process

After eligibility for the MCWP has been established and the client has chosen to receive MCWP services as an alternative to institutionalization, the Comprehensive Client Assessment shall be completed. The client then must be enrolled in the MCWP through the Department. This is accomplished by completing the following steps:

a. The enrollment portion of the most current version of the MCWP Enrollment/Disenrollment form must be completed fully and accurately;

b. The form must be faxed to the Department on (or as close as possible to) the enrollment date to a designated confidential fax line;

c. Department staff will process the enrollment and contact the Contractor (usually within 2 business days) with the client's MCWP Identification Number, followed by sending completed Enrollment/Disenrollment documentation to the Contractor; and,

d. If the information on the Enrollment/Disenrollment form is incomplete, inaccurate or Department staff cannot complete the enrollment process, the Contractor will be contacted to resolve the problem prior to a MCWP Identification Number being issued.

2. Disenrollment Process

Disenrollment may occur due to death of a client, a client moving out of Contractor's service area (see transfer of clients between Contractors, if appropriate), change in a client's Medi-Cal eligibility, if a client no longer meets eligibility criteria, etc. The following steps should be followed when disenrolling a MCWP Client:

a. The Disenroll portion of the original Enrollment/Disenrollment form used to enroll the client must be fully completed, using the actual date of death or discharge from the MCWP, the MCWP Identification Number and client social security number. The agency contact person and phone number must be reviewed for accuracy. If either has changed, the information must be updated to reflect current information. If the original form is unavailable, a new Enrollment/Disenrollment form must be fully completed with all of the required information;

b. The disenrollment date must be the same as the "Date Services Expire" date on the Notice of Action-Denial/Reduction/Termination of AIDS Medi-Cal Waiver Benefits (NOA), or if a NOA is not required, the date the client was actually disenrolled;

c. The form must be faxed to the Department on (or as close as possible to) the disenrollment date;

d. Department staff will process the disenrollment and send written confirmation to the Contractor;

e. State law and Medi-Cal regulations require that waiver programs give standard form MCWP2, *Notice of Action (Denial/Discontinuance) and State Hearing Notice Request, Your Right to Appeal the Notice of Action* to all applicants at initial application and to all existing clients when: 1) a client disputes the reduction or discontinuation of one or more services; or 2) the client is terminated or disenrolled from the MCWP. The NOA informs the applicant or client of his/her right to a fair hearing. A copy of the completed NOA and supporting documents must be maintained in the client file and the original sent to the client.

The NOA is NOT required when:

- The client dies.
- The client does not disagree with a reduction in frequency or units of service, or the discontinuance of one or more existing services within the MCWP.
- The post office has recently returned mail indicating no forwarding address and the client's whereabouts are unknown.

Ten-Day Advance Notice: The NOA is required at least 10 calendar days (excluding the mailing date) before the effective date of termination/disenrollment or disputed reduction in frequency or units of service in whole or in part.

Five-Day Advance Notice: The NOA is required five days in advance when the waiver agency has documentation of possible fraud by the client and the facts have been verified, if possible, through secondary sources.

Same-Day Notice: The NOA must be mailed or given to the client no later than date of action when:

- The client signs a clear written statement that he/she no longer wants services or signs an "Agreement to Participate" in another program (for example, AIDS Case Management Program); or

- The client gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information (for example, enrollment in a Medi-Cal Hospice or other program which does not permit "dual enrollment"); or

- The client has been admitted to an institution where he/she is ineligible for waiver services more than 30 days (for example, hospital or nursing facility); or

- The waiver agency establishes the fact that the client has been accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

The following table will assist you in determining when a 10-day letter or NOA must be sent to a client:

Condition	CMP	MCWP
Client is disenrolled from the MCWP, whether they agree or disagree		Yes NOA
Client is disenrolled from the CMP, if they agree	No 10-day letter	
Client is disenrolled from the CMP, disagrees	Yes 10-day letter	
services reduced, MCWP, client agrees		No NOA
Client services reduced, MCWP, client disagrees		Yes NOA
Client services reduced, CMP, client agrees	No 10-day letter	
Client services reduced, CMP, client disagrees	Yes 10-day letter	
Post office returned mail indicating no forwarding address and the client's whereabouts are unknown, MCWP		No NOA
Post office returned mail indicating no forwarding address and the client's whereabouts are unknown, CMP	No 10-day letter	
Client dies, MCWP		No NOA
Client dies, CMP	No 10-day letter	

f. The disenrollment process should not be used to change or correct enrollment information. Contact the Department enrollment coordinator to do so. A wrong Social Security Number cannot be changed in the system; this requires a VOID—not a disenrollment. The original enrollment form must be marked "VOID" and a new enrollment form must be completed with the correct Social Security Number.

D. CMP Enrollment and Disenrollment Process

1. Enrollment Process

After eligibility for the CMP has been established and the client has chosen to enroll in the program, the Comprehensive Client Assessment shall be completed. The client information shall be entered into the Database. The information is submitted to the Department on diskette with the monthly data reports. No personal identifiers are submitted. All data is transmitted with only the client's unique record number (URN) which is automatically generated by the database software when the Contractor enters the client information into the Database.

2. Disenrollment Process

When a client is disenrolled for any reason, including death, the reason and date of disenrollment is entered into the database and the information is submitted to the

Department on diskette with the monthly data reports for the month. When the disenrollment is not due to client death, it is required that the client be sent a letter at least 10 days prior to the date of disenrollment or decrease/discontinuation of services. The letter must detail why the client is being disenrolled from the CMP or services are being decreases/discontinued. A letter is not required if the client is in agreement with the disenrollment or decrease/discontinuation of services.

E. CMP and MCWP Enrollment is Time Limited

Client enrollment into either program should include discussion that as a client's medical and psychosocial status improves, the client will be assisted in transitioning to more appropriate programs and services, thus freeing valuable program resources for others who are more in need.

F. Transfer of Clients Between CMP and MCWP

It is often necessary for a Contractor to transfer a client from CMP to MCWP and vice versa.

1. Transfer from CMP to MCWP

   a. Discuss transfer with client when MCWP eligibility has been established. Note: The physician must certify the client's diagnosis prior to transfer;

   b. Disenroll the client from the CMP;

   c. Enroll the client in the MCWP as described above (C1). A Comprehensive Client Assessment does not need to be repeated. The effective date of enrollment will be the day after disenrollment from the CMP;

   d. If a client is eligible for the MCWP for more than one month and there is a program available to the client but he/she chooses not to transfer from the CMP, he/she must be disenrolled from the CMP. The client should be advised that as long as he/she remains eligible for the MCWP, no further services under the CMP can be provided. If the client has Medi-Cal with a SOC that cannot be met on a regular basis, he/she may remain enrolled in the CMP; and,

   e. The client record must clearly indicate dates of transfers between programs.

2. Transfer from MCWP to CMP

   a. Client must no longer be eligible for the MCWP and must meet the criteria for the CMP. Note: Current symptoms of HIV Disease, HIV Disease treatment or AIDS must be documented by the nurse case manager at reassessments;

b. Client must agree to enrollment in the CMP. An NOA must be sent (or given) to client, notifying him/her of pending disenrollment (if the client is not in agreement with the transfer). Client shall be aware of differences between programs;

c. MCWP disenrollment procedure must be followed prior to enrollment in the CMP (see paragraph *C.2.* of this section); and,

d. Dates of transfer between programs must be clearly documented in the client record.

G. Transfer of MCWP Clients Between Contractors

A client who has been enrolled in one Contractor's MCWP may not be enrolled in another Contractor's MCWP in the same calendar year without prior approval from the Department. As soon as it is determined that a MCWP client will be moving to a different MCWP Contractor's service area, or wishes to change providers, the steps below shall be taken. If the client does not notify their case manager or the Contractor of his/her intent to change providers, the steps below shall be carried out as soon as either Contractor is aware of the client's move/prior enrollment in the MCWP. Usually, the Department informs the Contractor if a client is enrolled in two programs simultaneously when the Social Security Number is entered into the system.

1. The NCM, SWCM or other CMP/MCWP staff will call the Contractor serving the area to which the client will be moving or wishes to transfer to and speak with the PD or other CMP/MCWP staff to inform them of the anticipated date of the pending move or transfer;

2. An agreement will be made as to what date the transferring Contractor will disenroll the client. The receiving Contractor may enroll the client on the following date, but not sooner;

3. A mutually agreeable decision will be made as to which Contractor will bill for Case Management Services and Administration fees for the month the transfer takes place. If the billing is to be divided (Case Management to one Contractor and Administration fees to the other), this will be agreed to by both parties. Neither the Case Management fee nor the Administration fee may be individually split-billed;

4. The Contractor transferring the client will provide the receiving Contractor and the Department with an accurate dollar amount of MCWP funds expended (or anticipated to be expended), including case management fees (administrative fees are not included), and the actual amount of funds available for the client as of the transfer date; and,

5. After the disenrollment has taken place and the client has been re-enrolled in his/her new location, the Department will send confirmation to both Contractors verifying dates of disenrollment/enrollment, billing for case management and administration fees, and amount of MCWP funds still available to/for the client.

H. Dual Enrollment in CMP/MCWP and the Early Intervention Program (EIP)

Clients generally may not be enrolled in CMP/MCWP and EIP. Individual exceptions, with appropriate documentation that no other resources exist, may be made.

The face-to-face comprehensive client assessment, which shall include the initial screening for program eligibility, must be initiated within five (5) working days of referral. Complete initial assessments do not have to be repeated if a client transfers between the CMP and MCWP within the same project. The comprehensive client assessment shall be appropriate for age, gender, cultural and linguistic factors. Identification of barriers to service utilization and delivery should be addressed as well as proposed resolutions to those barriers. The comprehensive client assessment shall include, but not be limited to the following elements:

A. Medical Status

Medical status means information about the client's physical condition establishing the diagnosis and any other medical problems the client may have. Medical information indicates the need for treatment and assists the case management team in evaluating and following up on issues identified by the client's medical providers. Medical records, including a copy of the most recent history and physical examination from the attending physician or primary care practitioner and discharge summary from an acute-care hospital (if applicable) must be requested for all clients.

The NCM (with input from the SWCM) will complete the CFA score (adults only), NFLOC (for MCWP clients only), and symptoms related to HIV Disease, HIV Disease treatment or AIDS (for adult CMP clients only). This information must be clearly documented in the client chart.

For adults, a certificate of eligibility from the appropriate medical provider verifying the diagnosis and confirming that he/she is responsible for the ongoing supervision of the client's HIV/AIDS care is required. Basic HIV/AIDS and Tuberculosis information must be included on the certificate of eligibility. For pediatric clients, the CDC Classification System for HIV in Children Under 13 Years of Age is required.

The certificate of eligibility/CDC Classification form must be received within 45 days of enrollment. A certificate of eligibility/CDC Classification form may also be obtained up to 45 days prior to enrollment. When an adult client transfers from CMP to MCWP a new certificate of eligibility is required (as of July 1, 2004, the NCM certifies symptoms for CMP while an MD must certify symptoms for MCWP; therefore, a new certificate must be obtained). When an adult client transfers from MCWP to CMP the NCM must document current symptoms in the subsequent reassessment. A physician or physician/primary care practitioner must certify symptoms for pediatric clients in both CMP and MCWP.

B. Nursing Assessment

The purpose of the initial nursing assessment is to assess the impact of illness on the client in order to establish eligibility and identify the need for services. The assessment

shall be for the purposes of the provision of case management services and for facilitating access by referral to needed medical, home, and social services. The initial nursing assessment includes a comprehensive systems review and must be performed by the NCM on or within 15 days prior to enrollment. The initial nursing assessment is vital because it provides the case manager with baseline information that assists in identifying the client's care needs, evaluating changes in the client's health condition, developing the service plan and coordination of services.

The nursing assessment includes both subjective and objective data that the NCM collects during the visit. Assessment of vital signs and any component of a physical examination as indicated or deemed necessary by the NCM to complete the assessment of the client should be performed in accordance with the Nursing Practice

Act. In addition to observation and interview, the initial nursing assessment includes a head to toe client assessment that utilizes observation, inspection, auscultation, and palpitation as indicated by the client's medical history, diagnosis and/or current medical symptoms and health status.

The assessment should also include information regarding pertinent physiological information, level of orientation, cultural information, current health status and habits, and need for and availability of caregivers. The NCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. A list of medications and known or increasing side effects, complimentary or alternative therapies, client adherence to the medication regimen, and any barriers to adherence should be documented. The nursing assessment must include a summary of the findings and a plan that outlines the responsibilities of the NCM for the next 60 days.

A health history must be obtained and documented by the NCM. In addition to a comprehensive review of HIV/AIDS, the health history should include all past significant medical events. This includes HIV and non-HIV related illnesses, AIDS-related illnesses, STD's, surgical interventions, tuberculosis history, and medications. The medication history should include current medications, over-the-counter medications and nutritional supplements as well as allergic or adverse symptoms. Immunizations (childhood and/or adult) or recall of childhood illness should be documented. Notation of hepatitis A, B, or C status and the need for vaccinations should also be included.

The NCM must also perform a nutritional assessment during the initial visit. The nutritional assessment assists in identifying areas where nutritional intervention is necessary and provides a baseline for later evaluation of the client's decline or progress. The nutritional assessment assists in determining the need for food supplements, assistance with meals, or the need for a nutritional consultation by a Registered Dietitian (RD). It evaluates the client's current and usual weight, food preferences, and health habits that may be actual or potential problems in achieving

optimal nutrition. The client's eating habits, dietary restrictions, food allergies or intolerances, and resources to meet nutritional needs. Physiological, medical, psychosocial, physical and financial issues affecting nutrition must be addressed.

C. Initial Functional and Level of Care Assessments

The NCM shall assess each client's functional status face to face as part of the eligibility determination. The CFA score shall be used for the functional assessment of adult clients. Pediatric clients do not require a CFA score at this time. The evaluation of the CFA score may take into account the client's overall abilities over time; it is not required that this evaluation reflect the client's abilities at the moment the evaluation is performed. Enrollment in CMP and MCWP requires an appropriate CFA score as assessed by the NCM, in consultation with the SWCM.

For MCWP, the client's level of care must be at the Nursing Facility level or higher (acute, sub acute) as described in the NFLOC Guidelines in Section X of this document. As part of eligibility screening, the NCM must evaluate the level of care. For children, the level of care determination must be based on needs and deficits relative to normative developmental progression. An example is that it would be expected that a child would not be able to administer his/her own medications, so that inability by itself would not contribute to determining the NFLOC. Complicated medical problems and fragile health status, however, would contribute to Nursing Facility or higher level of care.

D. Psychosocial Assessment

The purpose of the initial psychosocial assessment is to assess the psychosocial impact of illness on the client in order to establish eligibility and identify the need for services. The assessment shall be for the purposes of the provision of case management services and for facilitating access by referral to needed medical, therapeutic, home care, and social services. The initial psychosocial assessment must be completed by the SWCM on or within 15 days of enrollment. The assessment provides information about a client's social, emotional, behavioral, mental, spiritual, and environmental status. This assessment includes information about family and support systems, as well as information on the client's coping strategies, strengths and weaknesses, and adjustment to illness. In addition, the psychosocial assessment addresses the client's employment, education and cultural factors. Legal issues such as legal history, wills, Durable Power of Attorney (DPOA) and/or Durable Power of Attorney for Healthcare (DPOAH), and funeral arrangements are assessed. Substance use/abuse history and current risk behaviors must also be addressed. The SWCM also determines the client's resources and needs in regards to food, housing, and transportation. The SWCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. The psychosocial

assessment must include a summary of the findings and a plan that outlines the responsibilities of the SWCM for the next 60 days.

E. Financial Assessment

The financial assessment provides information regarding the client's current financial status. It addresses sources of income as well as expenditures, including housing, utilities, food, transportation, medical, clothing, entertainment, tobacco/alcohol, and other expenses.

F. Resource Evaluation

As a part of the eligibility process, a full benefits screening is completed. This screening addresses benefits and/or entitlements the client may be receiving or is potentially eligible for. These benefits should include private insurance, Medicare, Medi-Cal, Medi-Cal Managed Care, ADAP, CARE/HIPP, CCS and IHSS.

G. Home Environment Assessment

An assessment of the client's home environment will be performed as part of the initial comprehensive assessment. The home environment assessment may be performed by the NCM, SWCM or other CMP/MCWP staff to determine, at a minimum, whether or not environmental conditions could lead to the endangerment of the client or health care providers. The assessment shall address the structural integrity of the home, the availability of an adequate heating and cooling system, electricity, gas, and hot and cold running water. In addition, food storage and preparation facilities, basic furnishings, cleanliness, presence of hazards, functional plumbing, telephone services, laundry facilities, and care of pets (if any) shall be assessed. The home environment assessment must be performed in the client's home within 30 days of enrollment. If deficiencies are noted during the home environment assessment, there must be further description of planned interventions and appropriate follow-up.

If a client is homeless, the person performing the assessment must provide sufficient documentation that the client is receiving assistance with obtaining temporary or permanent housing.

H. Risk Assessment and Mitigation

The Centers for Medicare and Medicaid Services (CMS) is putting emphasis on the identification and follow-up of instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients. The comprehensive client assessment should include any history of abuse, neglect, or exploitation the client has experienced. If a history exists, the following information, if known, must be documented: the type of abuse that occurred, the identifying instance(s), if a report was made and to whom, and the outcome of that report.

A. Reassessments

Face-to-face reassessments provide information on the client's medical and psychosocial status necessary to update and maintain the service plan. Face-to-face reassessments must be made at least every 60 days.

1. Nursing Reassessments

The nursing reassessment must be performed by the NCM at least every 60 days for all clients enrolled in the CMP and MCWP. The nursing reassessment must include, at a minimum, the client's medical status including a systems review, nutritional review, and medication and treatment update (see Medication Sheet attached to Initial Nursing Assessment). The NCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. Follow-up on previously identified problems or concerns and identification of potential problems or concerns is required, as well as a summary of the findings and a plan that outlines the responsibilities of the NCM for the next 60 days. The CFA score assessment must be performed at this time (adults only) and for MCWP clients only, an evaluation and certification of the client's level of care. The client's ongoing program eligibility is determined during the nursing reassessment. The Comprehensive Service Plan and any changes to it are reviewed with the client during the reassessment.

2. Psychosocial Reassessments

The psychosocial reassessment must be performed by the SWCM at least every 60 days for all clients enrolled in the CMP and MCWP. The psychosocial reassessment must include an evaluation of the client's current social, emotional, behavioral, mental, spiritual, and environmental status, including support systems, employment, legal issues, substance abuse, and risk behaviors. The SWCM will also discuss transmission prevention with the client, addressing such issues as safe/safer sex, needle sharing, and harm reduction techniques. Follow-up on previously identified areas of concern and identification of potential problems or concerns is required, as well as a summary of the findings and a plan that outlines the responsibilities of the SWCM for the next 60 days. The Comprehensive Service Plan and any changes to it are reviewed with the client during the reassessment.

3. **Financial Reassessment**

The financial reassessment must be performed at least every 60 days with a review of information regarding the client's ongoing financial status. It addresses income and expenditures, including housing, utilities, food, transportation, medical, clothing, entertainment, tobacco/alcohol, and other expenses.

4. **Resource Evaluation Reassessment**

The resource evaluation reassessment provides information regarding the client's ongoing benefits eligibility status. A review must be performed at least every 60 days. It addresses benefits and/or entitlements the client may be receiving or is potentially eligible for.

5. **Home Environment Reassessment**

A reassessment of the client's home environment will be performed annually from the date of enrollment and when the client moves. The home environment reassessment may be performed by the NCM, SWCM or other CMP/MCWP staff to determine, at a minimum, whether or not environmental conditions could lead to the endangerment of the client or health care providers. The reassessment shall address the structural integrity of the home, the availability of an adequate heating and cooling system, electricity, gas, and hot and cold running water, In addition, food storage and preparation facilities, basic furnishings, cleanliness, presence of hazards, functional plumbing, telephone services, laundry facilities, and care of pets (if any) shall be addressed. If deficiencies are noted during the home environment reassessment, there must be further description of planned interventions and appropriate follow-up.

6. **Risk Assessment and Mitigation**

The Centers for Medicare and Medicaid Services (CMS) is putting emphasis on the identification and follow-up of instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients. Reassessments must address any instances of abuse, neglect, or exploitation the client has experienced in the past 60 days. If an instance has occurred, the following information must be documented: the type of abuse that occurred, the identifying instance(s), if a report was made and to whom, and the outcome of that report.

B. Client Contact

Telephone or face-to-face contact with the client between reassessments will be initiated as indicated by the NCM, SWCM, or other CMP/MCWP staff.

C. Interdisciplinary Team Case Conferences

The Interdisciplinary Team Case Conference (IDTCC) is an integral part of the model of care in the CMP and MCWP. The interdisciplinary team consists of those individuals participating in the process of assessing the multi-service needs of clients, planning for the provision of services to meet those needs, and evaluating the effectiveness and ongoing need for interventions as identified in the service plan. The team consists of, at a minimum, the client and/or his/her legal representative, the NCM, the SWCM, the attending physician or primary care practitioner, and the parent or guardian (if the client is a child). Interdisciplinary case conferences shall be held at least every 60 days for each client. At a minimum, the client's NCM and SWCM shall be present, and it is strongly recommended that the PD also be present. The client and/or his/her legal representative, the client's service providers and attending physician or primary care practitioner are encouraged to attend; if providers are unable to attend, information regarding the client's status and continued need for services will be collected prior to the case conference as appropriate. If unable to attend, the client and/or his/her legal representative may provide input to the NCM or SWCM during reassessments and other contacts. A review of the service plan and an evaluation of the services the client is receiving may be performed, as well as a review of the client's current status. The NCM and SWCM are expected to address the medical, psychosocial, housing and financial needs of each client and to discuss the roles each will play in fulfilling the client's service plan in the coming months. It is expected that participants will also discuss any changes in the client's status and the length of time case managers anticipate the client remaining on the program. Appropriate documentation will be maintained in the client chart including the names, licenses and/or degrees and titles of those attending the case conference, relevant information discussed, and whether the client or legal representative had input into the conference. Each Contractor must have a system in place to protect client confidentiality during IDTCC with multiple providers present.

This client-centered service plan shall be written, and include information regarding all of the services the client is receiving (regardless of funding source). The service plan is based on the service needs identified and documented in the Comprehensive Client Assessment and reassessments. Any service provided by CMP or MCWP funds must be a part of the service plan prior to the provision of that service.

A. Initial Comprehensive Service Plan

The interdisciplinary team utilizes the baseline information from the Comprehensive Client Assessment to develop the initial Comprehensive Service Plan. Both the NCM and SWCM are responsible for the development of the service plan. The Comprehensive Service Plan must be initiated at the time of enrollment and in the client chart within seven days of enrollment. The services provided shall not exceed the needs as identified. Services paid by the MCWP must not exceed the client's legitimate medical need. The plan shall demonstrate input and agreement from the client or legal representative. The service plan shall include, but is not limited to, the following elements:

1. Long-Term Goals

One or more brief statements expressing the primary reason(s) for the client's enrollment in the program and the purpose for the provision of case management services.

2. Identified Problems or Needs

A simple phrase stating the problem or need identified by the client and nurse case manager or social work case manager during the assessment, reassessment, or through other contact with the client. Documentation in the client record must support or describe the identified problem or need in more specific detail.

3. Stated Goals/Objectives

The stated goals and objectives must include the desired outcome. The outcome should address the resolution or management of the identified problem or need.

4. Services and Interventions

A brief description of the services the client is receiving, or will receive, which address the identified problem or need and whose aim is to meet the stated goals and objectives. The service, type of provider, the frequency, quantity, and

duration of the service, the payment source, and signature of the case manager authorizing or documenting the service must be included in the service plan (e.g. attendant care, XYZ Home Health Agency, four hours per day, twice weekly, for two months, case manager signature). The start date of the service must also be documented.

5. Documentation that the attending physician or primary care practitioner has been notified of the contents of the initial service plan.

6. Documentation that the client or his/her legal representative has had input regarding the contents of the initial service plan.

B. Review, Updates, and Revisions to the Comprehensive Service Plan

1. The client's service plan shall be updated and revised as problems and/or service needs change. All of the elements of the initial comprehensive service plan are required for revisions and updates.

2. A review and evaluation of all components of the service plan may be documented during the IDTCC with evidence of both nurse and social work case manager review. This must occur at least every 60 days.

3. The comprehensive service plan must be reviewed with the client during reassessments, with revisions as necessary.

C. Documentation Practices

Any and all problems identified, referrals made, services received, etc. (as documented in the assessment and reassessment) must be carried over and documented on the service plan. If an appropriate problem/need category does not exist, a new one is to be developed, including all other required elements of the service plan.

Introduction

The Centers for Medicare and Medicaid Services (CMS) is placing emphasis on the identification and follow-up of instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients. As a result, CMS is requiring the Department to collect and report instances of abuse, neglect, or exploitation affecting CMP/MCWP clients. Project staff must document risk assessment and mitigation in their assessments, reassessments, comprehensive service plans, and progress notes. The risk assessment and mitigation information will be included in the semi-annual progress reports submitted to the Department. The following information will assist case managers and/or other CMP/MCWP staff in appropriately handling such instances:

A. Types of Abuse and Identifying Instances. Examples include:

- Physical abuse: bodily injury, cuts, bruises, burns, unexplained injuries, physical restraints, evidence of sexual abuse, deprivation of food and water, pushing or hitting, intentional misuse of medications, causing pain.
- Isolation: preventing receipt of mail, phone calls, visitors, or contact with concerned persons.
- Financial: misuse of funds, unusual activity in bank accounts, checks cashed by others, suspicious changes in ownership, unpaid bills, missing belongings, undue influence to change documents, theft, embezzlement, misuse of property.
- Abandonment: left alone and unable to provide for own basic necessities of daily living.
- Sexual abuse: inappropriate exposure, inappropriate sexual advances, sexual exploitation, rape.
- Neglect by self or others: inadequate clothing, food, dehydrations, untreated medical conditions, misuse of medications, unsafe housing.
- Emotional or verbal abuse: threats, threats of harm or abandonment, isolation, intimidation.

B. Who Must Report

Instances involving adults: Endangered individual, community agency, social worker, nurse, other service provider, relative, or other concerned individual.

"Mandated Reporters" (Welfare and Institutions Code (WIC) §15630) are persons who have assumed full or intermittent responsibility for the care or custody of an elder or dependent adult, whether or not they are compensated for their services. Also included are administrators, supervisors and licensed staff of a public or private facility that provides care or services for elders or dependent adults, and elder or dependent adult care custodians (WIC §15610.17), health practitioners (WIC §15610.37), clergy members and

employees of county adult protective services agencies and local law enforcement agencies.

Instances involving children: Mandated child abuse reporters include all those individuals and entities listed in Penal Code (PC) §11165.7.

C. When To Report

Whenever, in a professional capacity or within the scope of employment, the following occurs:

- You observe or have knowledge of an incident that reasonably appears to be abuse, or
- You are told of an incident by the victim, or
- You reasonably suspect abuse

Two exceptions to the reporting requirement can be found in the WIC, §15630 (b)(2) and (3).

D. How To Report

Instances involving adults

- By telephone immediately or as soon as practically possible.
- By written report sent within 2 working days to the appropriate agency.
    - Form SOC 341 (6/04) Report of Suspected Dependent Adult/Elder Abuse.

Instances involving children

- By telephone immediately or as soon as practically possible.
- By written report sent within 36 hours of receiving the information concerning the suspected incident.
    - Form SS 8572 (12/02) Suspected Child Abuse Report

E. Whom To Report To

Instances involving adults

If the occurrence happened in a long term care facility, report to local law enforcement or the Long Term Care Ombudsman.

If the occurrence happened in the community, report to local law enforcement or Adult Protective Services.

Instances involving children
Report to local law enforcement, county probation department, county welfare department, or Child Protective Services.

F. Additional Information For Mandated Reporters

- Reporter may not be subjected to sanctions for making a report.
- Whenever two or more mandated reporters have knowledge about a suspected incident, they can agree that one of them will make a report.
- Law provides civil and criminal liability protection for anyone who makes a report in good faith.
- Reports made under the law are confidential.
- All mandated reporters are required to sign statements with their employers or with the State agency issuing their license or certificate, confirming knowledge of the reporting requirements and agreement to comply with the law.

Although most CMP/MCWP staff are already familiar with mandated reporting of abuse, neglect, or exploitation, the Department has not previously requested such information. The Department's sample assessment, reassessment, and comprehensive service plan forms have been revised to include the collection of this information. The QI/QM Guidelines also now include risk assessment and mitigation indicators and standards. CMP/MCWP projects are now required to include risk assessment and mitigation in written policies and procedures.

A. Contractor

The Contractor shall:

1. Provide fully qualified and properly degreed and/or licensed staffing as required:

   For the MCWP:

   One full-time equivalent (FTE) NCM for every 25-40 clients.

   One FTE SWCM for every 25-40 clients.

   For the CMP:

   One FTE NCM for every 30-45 clients.

   One FTE SWCM for every 30-45 clients.

   For CMP, it must be ensured that the total number of clients to be served falls within the range of clients the Contractor is allocated to serve. Exemptions may be allowed to serve as few as 25 clients and as many as 50 clients per team. The need for exemptions should be rare and granted by the Department only in extraordinary circumstances;

2. Ensure that NCM's and SWCM's caseloads fall within the allocated and budgeted ranges. NCM's and SWCM's may have different numbers of clients. These are duplicated clients, not different clients for each case manager;

3. Facilitate the goals of each client's service plan by fostering an environment of collaboration between nurses, social workers and other project staff, and capitalizing on the strengths of each discipline to provide services to each client that are timely and appropriate;

4. Provide private office space in which clients feel comfortable discussing highly personal and confidential matters, if they are seen in the office setting;

5. Subcontract with a sufficient number of service providers to allow the client or legal representative to choose from at least three (3) providers for each service when possible, based on the availability of participating service providers in a given geographic area. Services such as in-home skilled nursing, in-home attendant care, homemaker services, psychotherapy, and nutritional counseling shall be

subcontracted for if identified as a client need but not available to the client in the community through other funding sources;

6. Make good faith efforts to secure subcontracts to provide client services with qualified providers desired by the client;

7. Review service provision by and credentials of subcontractors (and their staff) at least annually, to ensure that contract requirements are met;

8. Make every effort to assure access to bilingual service providers and interpreter services for clients whose ability to speak and/or understand English is limited;

9. Make every effort to assure access to contact persons or organizations that can assist with communications for persons who are hearing, vision, and/or mobility impaired (in accordance with the Americans With Disabilities Act of 1990);

10. Regularly participate in the meetings of the local Title II HIV Comprehensive Care Consortium or Title I Planning Councils where appropriate, for all service areas;

11. Develop interagency and intra-agency working relationships that support the case management programs;

12. Implement a QI/QM Program as approved by the Department to continually evaluate and improve the quality of services provided by the Contractor under this contract. The Contractor shall:

    a. Designate a QI/QM Coordinator;

    b. Obtain Department approval of Contractor's QI/QM Plan, policies, and procedures. The QI/QM Plan, policies, and procedures must be submitted to the Department by July 31 of each year. At a minimum the QI/QM Plan shall include:

        (1) Indicators of quality;
        (2) Frequency indicators are monitored;
        (3) Standards for compliance
        (4) Name and title of Contractor's employee designated to review QA findings; and,
        (5) Name and title of Contractor's employee designated responsible for corrective action; and,

    c. Submit a summary of the results of QI/QM monitoring with each progress report required under this contract (even though summaries are submitted every six months, QI/QM activities should be conducted on an ongoing basis).

13. Maintain current, written policies and procedures (reviewed annually) for:

    a. Waiting list, including an acuity-based system for enrollment priority, guidelines for regular contact with referred individual, and referrals to other programs and services the individual may access (use of a waiting list is optional; if not utilized have a policy stating so);

    b. Transportation, housing, utilities, and food assistance;

    c. Client grievances;

    d. Client enrollment and disenrollment, denial of services;

    e. Cost-Avoidance (methods by which the utilization of all other resources or funding sources will be documented);

    f. Criteria for admission and services to clients in residential facilities (use of residential facilities is optional; if not utilized have a policy stating so); and,

    g. Retention and confidentiality of client records (including access, release, storage, and disposal);

    h. Continuity of case management services during expected and unexpected absences of NCM's and SWCM's;

    i. Tuberculosis Screening requirements

    j. Risk assessment and mitigation

14. Prepare an annual Outreach Plan targeting institutionalized populations and those disproportionately affected by HIV/AIDS and to identify and provide services to underserved populations in the Contractor's service area;

15. Prepare and submit required reports to the Department in a timely manner; mid-year progress report is due January 31st; annual progress report is due July 31st.

16. Prepare and submit CMP invoices to the Department no later than 30 calendar days following the end of the billing period, unless otherwise approved in writing by the Department. A final undisputed invoice shall be submitted for payment no more than 90 calendar days following the expiration or termination date of this agreement;

17. Prepare and submit claims to EDS in accordance with instructions provided in the Medi-Cal Provider Manual. The Department shall reimburse for correctly prepared and submitted claims received within six month following the month in which services were provided to eligible MCWP clients. Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delayed reasons allowed by regulation; and,

18. Ensure that all provisions of HIPAA are implemented and enforced.

19. Submit to the State, each month, thirty days after the report period ends, a copy of the diagnosis and history database on a disk consistent with State format and structure. In addition, send to the State a hard copy (paper report) of the entire diagnosis database, and the current report month data from the history database. Contractors who submit data reports more than 60 days after the report period ends may have their invoices held until the report is received.

20. Document that all staff are free of communicable tuberculosis. These annual tuberculosis (TB) screening requirements apply to all CMP employees or volunteers who are at a site (building) where clients receive services including case management. They also apply to agency staff paid for by other funds or sources that provide services to CMP clients.

B. Core Case Management Team

The core case management team's collective responsibilities include:

1. Participation in IDTCC for each client;

2. Review and revision of each client's service care plan; and,

3. Provision of stable, dependable, and professional case management services across institutional, community, and agency boundaries.

C. Nurse Case Manager

The NCM shall:

1. Assure that each client enrolled in the case management program meets medical and functional eligibility criteria;

2. Perform and coordinate initial comprehensive nursing assessments and ongoing reassessments including an assessment of the client's level of care (for MCWP clients only) and functional status;

3. Participate fully in case management activities within his/her area of expertise;

4. Participate fully with the core case management team, which assures that the team is the primary service planning body and that the client or client's legal representative and family (when appropriate) is involved in the development and revisions of the service care plan;

5. Monitor services and assure that only authorized services are provided, maximizing the use of all other available resources prior to the utilization of CMP or MCWP funds;

6. Consult with the client's attending physician, primary care practitioner and/or other medical providers as needed, to coordinate plans of treatment and advocate for the client as necessary;

7. Work with the client and case management team to develop and implement a service plan for each client with review and appropriate revision based on comprehensive assessments and reassessments, case conferences, and service needs identified by the core case management team (including the client or his/her legal representative).

8. Foster intra-agency and interagency working relationships to help accomplish goals;

9. Participate in QA activities as described in the QI/QM Guidelines;

10. Empower clients in decision-making for health care and service planning;

11. Maintain records and collect data as required by the Department and professional standards;

12. Advocate for the needs of the individual client;

13. Participate in outreach activities to the entire target population, including agencies serving the homeless population; and,

14. Assist in preparing an annual outreach plan to institutionalized and underserved populations in the community served by the project.

15. Identify and follow up on instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients.

D. Social Work Case Manager

The SWCM shall:

1. Perform and coordinate initial psychosocial assessments and ongoing reassessments;

2. Participate fully in case management activities within his/her area of expertise;

3. Participate fully with the core case management team, which assures that the team is the primary service planning body and that the client or client's legal representative and family (when appropriate) is involved in the development and revisions of the service plan;

4. Monitor services and assure that only authorized services are provided, maximizing the use of all other available resources prior to the utilization of MCWP or CMP funds;

5. Consult with the client's attending physician, primary care practitioner and/or other medical providers as needed, to coordinate plans of treatment and advocate for the client as necessary;

6. Foster intra-agency and interagency working relationships to help accomplish goals;

7. Ensure that the client's psychosocial needs are addressed in accordance with the service plan;

8. Work with the client and case management team to develop and implement a service plan with review and appropriate revision based on comprehensive assessments and reassessments, case conferences, and service needs identified by the core case management team (including the client and/or his/her legal representative);

9. Promote understanding of the psychosocial factors impacting persons with HIV Disease or AIDS;

10. Identify and assist clients in accessing benefits and entitlements, resources, and information and referral services for psychosocial needs;

11. Consult with other social service providers as needed to assure continuity of care and prevent duplication of services;

12. Participate in QA activities as described in the QI/QM Guidelines;

13. Empower clients in decision-making for service planning;

14. Maintain records and collect data as required by the Department and professional standards;

15. Advocate for the needs of the individual client;

16. Participate in outreach activities to the entire target population, including agencies that serve the homeless population; and,

17. Assist in preparing an annual outreach plan for institutionalized and underserved populations in the community served by the project.

18. Identify and follow up on instances of abuse, neglect, and exploitation that bring harm or create the potential for harm to clients.

E. Contractor/Core Case Management Team

Introduction: CMP/MCWP contracts require projects to maintain written policies for admission and services when a CMP/MCWP client lives in a residential facility licensed by DSS, Community Care Licensing Division (CCLD). Additionally, CMS requires MCWP projects to establish necessary safeguards to protect the health and welfare of persons receiving services under the Waiver. Information and requirements for CMP/MCWP case managers is summarized below. Also see *Chapter 2, Section F, Residential Facilities, Client Admission, and Services* in the *POM* for the following information and requirements:

- Summary Description of DSS/CCLD Residential Facilities

- Comparison of Adult Residential Facilities, Residential Care Facilities for the Chronically Ill, Residential Care Facilities for the Elderly, Small Family Homes, and Foster Family Homes

- Care and Supervision

- Requirements that Apply to all Residential Facility Types

- Requirements that Vary by Facility Type

- Residential Facilities Exempt from Licensure

Provision of Basic Services by Residential Care Facility Direct Care Staff (DCS): Licensing requirements describe the basic services to be provided by DCS employed by the residential facility (e.g. skilled nursing, attendant care, homemaker services, etc.). CMP/MCWP funds cannot be used as a replacement for these basic services. When CMP/MCWP funds are used to pay for "non-basic" or additional services, the client file must document the individual client's specific need for the type and amount of services to be provided over and above those provided by the facility. Note: DCS are individuals employed by the facility that provide direct care services to the residents including, but not limited to, assistance with activities of daily living.

Provision of Case Management: RN case management for health and social services is a basic service under RCFCI licensing requirements. Section 87860(3) [California Code of Regulations (CCR), Title 22, Division 6, Chapter 6] states: "The registered nurse may be an employee of the home health agency, the residential facility, or another organization with a contract with the residential facility." If the residential facility does not have a NCM on staff, the CMP/MCWP provider should have a written agreement regarding the case management services available through CMP and MCWP for clients who remain eligible and need case management. This agreement should also address how the licensing requirement for RN case management services will be met if the client loses CMP or MCWP eligibility. This is to ensure that there is no pressure from the facility to maintain client enrollment if he/she is no longer eligible solely for the purpose of maintaining a stable residence.

If the residential facility does have RN case management on-site, then there must be a written agreement between the RCFCI and the CMP/MCWP provider as to the roles and responsibilities of each NCM. The client chart must document the need for CMP/MCWP case management over and above the case management available form the facility. The CMP/MCWP case management team must be the primary case managers. Reimbursement for case management is based on comprehensive assessment, identification of service needs and the development, implementation, and periodic evaluation of a written service plan by both the NCM and the SWCM.
If case management services are not needed by the client or if the client's case management needs are met through services available at the facility, he/she should not be enrolled in CMP or MCWP. Neither of these programs should be used solely as a funding source for direct care services such as transportation, attendant care, etc.

CMP/MCWP Staff Knowledgeable about Requirements: CMP/MCWP staff (i.e. clients' NCM and SWCM) should be knowledgeable as to the requirements for each facility type in which their client(s) reside and that this knowledge include:

- Basic service the residential facility is required to provide.
- Facility responsibility for providing *Care and Supervision* (see *Care and Supervision* section in the POM).
- Required facility staffing-ratios for day and night care and supervision.

- Admission and ongoing requirements including ambulatory status and TB screening.
- Allowable and prohibited medical conditions.
- General requirements for allowable conditions.
- Medications, storage of medications, self-administered medications, medication procedures, and medication documentation.
- Scheduled and controlled drugs, usage, and disposal.
- PRN medication, usage, and disposal.
- The residential facility's admission policy regarding persons who request a "Do Not Resuscitate Order."
- Facility's and adult client's agreed plan for relocating client's children and/or family when the adult client is hospitalized, relocated, becomes unable to meet their child's or children's needs, or dies.
- Identify the name of the CMP/MCWP case managers(s) who has/have responsibility to be knowledgeable about criteria for acceptance and retention of facility residents.
- Include a copy of the regulations for each facility type in which a client resides, in the central file at the CMP/MCWP project.

F. Attending Physician/Primary Care Practitioner

The attending physician or primary care practitioner is responsible for:

1. The medical care of the client;

2. The assessment and documentation of the client's medical status; and,

3. Consultation with the nurse case manager and the core case management team as needed.

G. Other Support Staff

Other support staff may vary depending on the needs of the Contractor, but basic support staff responsibilities are as follows:

1. Case Aide

A case aide may assist the nurse case manager or social work case manager with practical arrangements for meeting service needs. There are no minimum qualifications for the case aide, but knowledge of a community's service resources for persons with HIV Disease or AIDS and of eligibility for government programs/benefits is required. Functions a case aide may perform include financial assessment/reassessment, home environment assessment/reassessment, resource evaluation, transportation, delivering

vouchers, assisting with benefits counseling and referrals, and advocating for the client and client resources. A case aide may not perform nursing or psychosocial assessments or reassessments, or the development of the initial service plan. A case aide may perform home environment and financial assessments and reassessments.

2. Benefits Counselor

   The benefits counselor may assist the social work case manager in providing information, referrals, and assistance to the client in securing and maintaining benefits and entitlements.

H. Home Health Agency or Home Care Organization

The home health agency or home care organization subcontracted to provide skilled nursing or attendant care services to clients prepares a nursing plan of care including the diagnosis, the assessment of needed care, interventions, goals, and evaluations. The subcontractor implements the nursing plan, provides supervision to their unlicensed staff, provides feedback to the core case management team, and participates in monthly case conferences (when possible). The plan of care must be provided to the Contractor for inclusion in the client's CMP or MCWP file. The subcontractor must ensure that staff meets certification, education, and health requirements. When a home care organization is the subcontractor, the supervision requirements for unlicensed (certified) staff are the same as for a licensed home health agency (no less frequently than every 62 days). If the home care organization is unable to provide the supervision of the attendants, they may enter into an agreement where the MCWP or CMP Contractor provides the supervision. Only Certified Home Health Aides or Certified Nursing Assistants may provide attendant care.

I. Provider of Homemaker Services

The entity subcontracted to provide homemaker services is responsible for providing services as authorized by the CMP or MCWP nurse or social work case manager. Homemaker services consist of general household activities (meal preparation, light housekeeping, and routine household care). They may only be provided by an individual who has received training in the areas of HIV/AIDS, basic infection control, and confidentiality. Services provided are in addition to, not in place of, services authorized by the In-Home Supportive Services (IHSS) Program.

NOTE: Licensure is not required if agency is providing attendant care only.

A. Reasons for Documenting

1. To communicate client assessment, service planning, and implementation information to core case management team members;

2. To meet client service record legal requirements;

3. To substantiate care decisions made with or on behalf of the client;

4. To collect data necessary for client care and program decisions;

5. To allow an assessment of the efficacy and appropriateness of funded services; and,

6. To document the activities of case management and related activities in a uniform, comprehensible manner.

B. Documentation Practices

The client service record must be kept as part of the contractual obligation to the Department, and should follow the accepted guidelines for record handling and documentation practices for health care records.

1. No section/element of a form should be left blank. If a client chooses not to provide information or a case manager feels that a particular area should not be addressed at the time, the section/element should be noted with an "N/A," "deferred," etc.

2. Each client must have a separate chart. It is optional to assign each client chart an identification number.

3. Observations and conclusions documented should be objective, professional, and non-judgmental;

4. Records should follow a standard format with standardized documents;

5. Documentation must be legible, typewritten, computer-generated, or handwritten in ink. It must be dated and signed (with professional title);

6. Contractor policy should assign responsibility for recording documentation with time frames; and,

7. Corrections should be made by drawing a single line through the entry, writing "error" and dating and initialing the entry. The use of "white-out", rewriting pages

and destroying the original documentation or other correction methods are not acceptable.

8. Per Health and Safety Code Section 123149 (g), "Any health care provider subject to this section, choosing to utilize an electronic record keeping system, shall develop and implement policies and procedures to include safeguards for confidentiality and unauthorized access to electronically stored patient health records, authentication by electronic signature keys, and systems maintenance." Per the Department, if electronic records are to be printed and filed in a client chart, the record must be originally signed by the appropriate case manager(s).

C. Record Handling and Storage

1. All documents should be secured in the records and protected from potential damage;

2. No forms shall be destroyed or removed from the records once entered into them;

3. Records should be available only to the agency staff directly responsible for filing, charting, and reviewing, and to State and Federal representatives as required by law. They should be protected from unauthorized access; computerized or electronic records must be similarly protected and have appropriate safeguards. Client records must be kept in a locked storage area, again accessible only to the agency staff directly responsible for filing, charting, and reviewing; and,

4. Contractor policy should address the manner and length of time the documents will be stored, as well as removal from storage and destruction of records. A plan must be specified for record storage and retrieval if the organization were to close. (Current State law requires adult medical records be kept at least until 1 year after the minor has reached the age of 18 years but in no case less than seven years.)

D. Confidentiality

1. As health care providers, CMP and MCWP Contractors and staff must comply with all provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996;

2. Medical/healthcare information cannot be released verbally, in writing, or copied from records without a written consent for the release of information signed by the client (or legal representative). This consent must specify the type of information to be released and to whom, and may be revoked at any time by the client (or legal representative);

3. The Contractor shall have written policies addressing the circumstances and processes by which all or part of a record may be released and to whom. Original documentation may be released only when required by court subpoena, otherwise photocopies should be provided;

4. Current State and Federal law will be followed regarding client access to records;

5. The Contractor shall maintain signed statements of confidentiality for employees and volunteers who have access to client records;

6. The Contractor will protect client names and other identifying information (name, address, telephone number, date of birth, social security number, driver's license number, any number, symbol or other identifying particular assigned to the client). Identifying information may only be used to provide case management and other services offered by the CMP and MCWP;

7. The Contractor will maintain a confidential fax machine. Fax cover sheet should address the following information: who is the intended recipient, what type of information is included, and instructions for unintended recipients; and,

8. When using a personal computer, the Contractor will protect client confidentiality and anonymity within the database by every reasonable means, including one or more of the following:

   a. LAN drive that is password protected, at a minimum password protection to log on to PC;

   b. providing a workstation in a separate room away from general population and unauthorized staff;

   c. the use of encryption software; and,

   d. securing the work station to the desk or wall, if necessary.

E. Contents of a Client Chart

1. Outline describing order and contents of client chart

2. Resource Evaluation Record: policy and eligibility verification;

3. Cost Avoidance activities record;

4. Adults: Physician certification of HIV Disease or AIDS with symptoms related to HIV Disease, HIV Disease treatment or AIDS (MCWP);

Pediatrics: CDC Classification System for HIV in Children Under 13 Years of Age;

5. Adults: Physician/Primary Care Practitioner certification of HIV Disease or AIDS (CMP);

   Pediatrics: CDC Classification System for HIV in Children Under 13 Years of Age;

6. Client (or legal representative) signed Informed Consent/Agreement to Participate, Authorization for the Release of Medical Information, Client's Rights in Case Management, Grievance Policy, and the NOA;

7. Initial comprehensive client assessment: physical, functional (CFA score – adults only; pediatrics – none at this time), nutritional, health history, medication, NFLOC (for MCWP), psychosocial, financial and home;

8. Ongoing client reassessment at least every 60 days or more often as needed: physical, functional (CFA score – adults only; pediatrics – none at this time), nutritional, medication, NFLOC (for MCWP), psychosocial, financial and home (annually and when client moves);

9. Home Health Aide Plan of Care (for clients receiving attendant care or skilled nursing services)

10. Service Plan: review every 60 days and as needed; and,

11. Progress notes - Nurse Case Manager and Social Work Case Manager – may be documented in other forms, such as the assessments, reassessments, IDTCC, service plan:

    a. Current physical, psychosocial, and functional status and changes;

    b. Education, counseling, referrals, or other direct services provided to the client;

    c. Phone contact with client, caregivers, service providers, physicians, etc.;

    d. Summary of interdisciplinary team case conference every 60 days (may be documented on IDTCC form);

    e. Copies of correspondence, medical, and provider service records;

    f. Data collection forms including initial enrollment and summary of monthly services provided summary (may be centrally located) and,

    g. Documentation of the need for the specific services delivered (may be documented on assessments/reassessments).

Form	Number	Revision Date	Type
CMP Informed Consent/Agreement to Participate	CMP 1	3/06	Mandatory
CMP Informed Consent/Agreement to Participate	CMP 1 Spanish	4/02	Mandatory
MCWP Informed Consent/Agreement to Participate	MCWP 1	3/06	Mandatory
MCWP Informed Consent/Agreement to Participate	MCWP 1 Spanish	4/05	Mandatory
CMP Certificate of Eligibility-Physician or Primary Care Practitioner	CMP 2*	4/05	Sample
MCWP Certificate of Eligibility-Physician	MCWP 2*	4/05	Sample
CDC Classification System for HIV Children Under 13 Years of Age	CMP/MCWP 6	3/06	Guidelines
MCWP Enrollment/Disenrollment Form	MCWP 3	4/05	Mandatory
MCWP Notice of Action (NOA)	MCWP 4	7/04	Mandatory
Request for a State Hearing	MCWP 4 Attachment	7/04	Mandatory
MCWP Notice of Action (NOA)	MCWP 4 Spanish	7/04	Mandatory
Request for a State Hearing	MCWP 4 Spanish Attachment	7/04	Mandatory
Nursing Facility Level of Care (NFLOC) Guidelines	MCWP 5	4/05	Guidelines
Authorization to Exchange Confidential Information	CMP/MCWP 1	4/05	Sample
Authorization to Exchange Confidential Information	CMP/MCWP 1 Spanish	10/05	Sample
Client Rights in Case Management	CMP/MCWP 2	1/98	Sample
Client Rights in Case Management	CMP/MCWP 2 Spanish	9/04	Sample
Transfer Log	CMP/MCWP 3*	4/05	Sample

Mandatory Forms: must be used “as is”; no changes may be made to these forms.
Sample Forms: may be revised to meet an individual contractor’s needs but must contain all of the elements within the forms. Forms can be identified as either sample or mandatory by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (S) for sample forms or (M) for mandatory forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

***** These are fill-and-print forms.

Authorization to Exchange Confidential Information

CMP and MCWP project staff shall NOT disclose or receive medical information regarding a client without first obtaining a written *Authorization for the Exchange of Confidential Information*, except for the purpose of care or treatment. Authorizations for exchange of confidential information are subject to California Civil Code (CCC), Part 2, Section 56; see Internet link http://www.leginfo.ca.gov/cgi-bin/calawquery. It is suggested that projects consult their agency legal counsel with any questions not specifically addressed in the CCC. The *Authorization for Exchange of Confidential Information* shall include the following elements (CCC, Part 2, Section 56.11):

- It must be handwritten or in typeface no smaller than 8-point size.
- It must be clearly separate from any other language on the same page and executed by a signature that serves no other purpose than to execute the authorization.
- It must be signed and dated by the patient or the legal representative of the patient. [Note: additional information regarding who may sign the authorization and under what circumstances is included in CCC, Part 2, Section 56.11 (c).]
- The specific uses and limitations on the types of confidential information to be disclosed must be stated.
- The name or functions of the health care provider that may disclose the information must be stated.
- The name or functions of the persons or entities that are authorized to receive the information must be stated.
- It must state the specific uses and limitations on the use of the confidential information by those authorized to receive it.
- A *specific* date after which the provider is no longer authorized to disclose the information must be stated. (**Note**: The length of time an authorization may be valid is to be determined by the project; however, many contractors use two years.)
- The form must advise the person signing the authorization of the right to receive a copy of the authorization.

CCC, Part 2, Section 56.15 states that an individual may cancel or modify an authorization. The cancellation or modification of any authorization shall be effective only after the provider of health care actually receives written notice of the cancellation and modification.

As health care providers, CMP/MCWP projects must comply with all provisions of the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

See the form in this section, Authorization for the Exchange of Confidential Information (CMP/MCWP 1).

Eligibility and Requirements for Children Under 13 Years of Age

The CDC Classification System for HIV in Children Under 13 Years of Age (MMWR September 30, 1994/Vol. 43/No. RR-12) is used to determine eligibility for children. Please see the form in this section, CMP/MCWP 6.

For MCWP, pediatric clients under 13 years of age must be classified in clinical category A, B or C. For MCWP, a physician must complete the form.

For CMP, pediatric clients under 18 months of age may be classified in clinical category A, B, C or N. Pediatric clients 18 months of age to under 13 years of age must be classified in clinical category A, B, or C. For perinatally exposed children under 18 months of age, Prefix E should be added until their HIV status is confirmed. For CMP, a physician or a primary care practitioner may complete the form.

When a pediatric client reaches the age of 13 the CFA Score must be used for ongoing eligibility purposes. The client must continue to meet this and all other eligibility requirements for the specific program in order to continue enrollment. NOTE: The Nursing Facility Level of Care must be met or exceeded for all MCWP clients, including children. This Level of Care must continue to be met for ongoing MCWP eligibility. If the client is enrolled in MCWP and the CFA Score is greater than 60, the client must be disenrolled; the CMP may be appropriate. For clients enrolled in either program, if the CFA Score is greater than 70 and the CMP contractor is utilizing the CMP Client Expansion of Eligibility, the client may continue to be enrolled in the CMP. The need for ongoing intensive case management and the lack of other community resources or programs to meet those needs must be documented. All Client Expansion of Eligibility criteria and requirements must be met.

As the CMP/MCWP do not provide “medical care related to the diagnosis or treatment of the disease”, no new Agreement to Participate, Authorization for Release of Medical Information, or any other forms are required to be signed by the client after his/her 13th birthday. The forms signed at enrollment continue to be in effect. Until a minor turns 18 years old, the parent or legal representative must sign all forms requiring the client’s signature. Whenever someone signs forms other than the client, the relationship to the client must be indicated on the form.

At the age of 18, the client must re-sign all forms, unless a conservator or legal representative has been appointed. If this is the case, the legal representative must sign all forms for continued client enrollment in the CMP or MCWP.

AIDS CASE MANAGEMENT PROGRAM (CMP)
INFORMED CONSENT/AGREEMENT TO PARTICIPATE

APPLICANT'S NAME: Chart Number:

I have been informed of services of the AIDS Case Management Program (CMP). I understand that as part of my application for services under the CMP, the Nurse Case Manager and Social Work Case Manager must evaluate my condition. My Nurse Case Manager and Social Work Case Manager will coordinate the care I receive at home. I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding. The CMP is constructed so that I will incur no cost as a result of my participation. However, the CMP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the CMP program.

2. The Nurse Case Manager and Social Work Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.

3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on CMP participants (*personal identifiers deleted*) may be used for research and publication. A certificate of confidentiality is in place that specifies that researchers keep client information confidential. The CMP is committed to maintaining the highest possible level of confidentiality.

4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular case conferences, consisting of CMP staff, my physician and contractors supplying direct care services to me.

5. My participation in the CMP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the CMP at any time if it's in my best interest to do so.

6. I understand that I must meet all CMP eligibility requirements, including medical needs and condition, and that if I am hospitalized I will not receive CMP services until my discharge. If I am hospitalized for more than 30 days, I will be disenrolled from the CMP. I also understand that I must comply with CMP program requirements as explained to me at enrollment.

7. I agree to cooperate fully with Agency/CMP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.

8. I have the right to ask any questions concerning the CMP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the CMP program, I may contact my Nurse Case Manager or Social Work Case Manager.

9. I understand that CMP staff are mandated reporters. I also understand that as mandated reporters they have to report situations such as elder or dependent abuse, child abuse, suicidal ideations, or homicidal ideations. The reasoning for such reports, as well as examples of such instances, has been explained to me.

10. Client Initials_____I acknowledge that I have received a copy of the Agency Grievance Policy.

    Client initials_____I acknowledge that I have received a copy of the Client Rights.

I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.

All questions I have concerning the CMP at this time have been fully answered. If I have further questions, I should contact the CMP Staff at:_____

Applicant's Signature: Date

Agency Representative: Date:

AIDS Case Management Program (CMP)
Consentimientó de Participacion

Nombre del Cliente: _____# de Expediente_____

Yo he sido informado sobre los servicios del Programa de Manejamiento de Casos del SIDA (CMP). Entiendo que como parte de mi aplicación para recibir servicios de Manejo de Casos, el/la Enfermero/a debéra evaluar mi condición. La/el manejador de casos o trabajador/a social será responsable de coordinar servicios en mi casa. Yo entiendo que:

1. Yo participáre en el proceso de decidir que servicios recibiré y seré notificado de los servicios, y de cualquier cambio en éstos. Estos servicios se basan en la necesidad y disponibilidad de fondos. Ningún costo está relacionado con mi participación en este programa. Sin embargo, los costos asociados con mi cuidado se cobraran a otras entidades como poliza de seguro medico, antes de cobrarlos al programa.

2. El/la manejador/a de casos mantendrá información sobre mi progreso y diseñará un programa de servicios para mí. El tipo y la cantidad de estos servicios seran determinados por medio de sesiones individuales y de juntas de el equipo acargo de mi cuidado.

3. Entiendo que se me haran preguntas personales que incluyen; mi nombre, raza, género, salud y otra información importante. Ninguna información adquirida sera usada en contra mía ni se dará a conocer sin antes dar mi consentimiento como lo proveé la ley. Sin embargo, información general (sin ninguna clase de identificación personal) puede ser adquirida y usada en estudios o publicaciones de estos. Un certificado que obliga a los cientificos que conducen estudios a mantener la confidencialidad se mantiene en archivo. El programa de CMP esta compromentido a mantener la mas estricta confidencialidad.

4. La información contenida en mi expediente sera vista solamente por el personal aprobado del programa, y otras personas que están a cargo de mi cuidado o como lo específica la ley. Entiendo que mi caso pueda ser discutido en reuniones de casos, a las cuales asisten el personal del programa CMP, mi doctor y otras personas que me brindan servicios.

5. Mi participación en el programa de CMP es voluntario y yo puedo salir de el programa en cualquier momento sin represalias o pérdida de otros servicios por los cuales yo califico. Mi cuidado médico no se verá afectado por salirme del programa. Ademas, mi doctor puede darme de alta del programa si el/ella cree que es por mi bien.

6. Entiendo que necesito llenar todos los requisitos para el programa de CMP, los cuales incluyen necesidades y condición médica, y si llego a ser hospitalizado, yo no recibiré servicios mientras esté en el hospital. Estoy de acuerdo a seguir los reglamentos de el Programa como me lo han explicado.

7. Tengo el derecho de hacer preguntas de el programa de CMP en cualquier momento. Se me informará sobre cualquier cambio en el programa. Puedo manterme en contacto con mi trabajador/a de casos.

8. Estoy de acuerdo en cooperar con el personal de CMP y con los proveedores de cuidado. Consiento obstantemente de cualquier comportamiento hostil, ya sea verbal, abusivo, ó amenazante; al no cumplir con estos requisitos, mis servicios serán suspendidos.

9. Iniciales de el Cliente _____ Yo he recibido una copia de las Reglas de Quejas de la Agencia.

   Iniciales de el Cliente _____ Yo he recibido una copia de los Derechos de el Cliente

Certifico que he leido y entiendo la información aqui escrita sobre el programa. Con mi firma indico que estoy de acuerdo a participar en el programa. Se me proporcionará una copia de este acuerdo en el momento que lo necesite.

Todas las preguntas sobre el programa han sido contestadas completamente. Si tengo preguntas en el futuro, llamaré a la siguiente persona al telefono: ( ) _____-_____

Firma de el Aplicante _____ Fecha _____

Representate de la Agencia _____ Fecha _____

AIDS MEDI-CAL WAIVER PROGRAM (MCWP)
INFORMED CONSENT/AGREEMENT TO PARTICIPATE

APPLICANT'S NAME: Medi-Cal #

I understand that as part of my application for services under the MCWP, the Nurse Case Manager and Social Work Case Manager must evaluate my condition. My Nurse Case Manager and Social Work Case Manager will coordinate the care I receive at home. If I am eligible and choose to participate, I understand that:

1. I will participate in the process for deciding the services that I will receive and will be notified of what services I am to receive and any subsequent changes made to these services. These services will be based on need and availability of funding and that it is cost effective to provide these services. The MCWP is constructed so that I will incur no cost as a result of my participation. However, the MCWP monies will be the last source of payment to provide services; if care is available through another entity, e.g., insurance policy, then that source will be billed before the MCWP program.

2. The Nurse Case Manager and Social Work Case Manager will keep track of my progress and will develop a personalized service plan. The types and quantities of services will be determined through regular meetings with me and interdisciplinary team meetings.

3. I will be asked to provide personal information about myself including name, race, gender, health, and other pertinent information. No identifying information collected will be used against me or will be released without my consent, except as allowed by law. However, summary data based on MCWP participants (*personal identifiers deleted*) may be used by researchers for research and publication. The MCWP is committed to maintaining the highest possible level of confidentiality.

4. Information from my case record will be seen only by approved staff, consultants, and service providers, who will be serving me, or as otherwise provided by law. I understand that my case may be discussed at regular Case Conferences, consisting of MCWP staff, my physician and contractors supplying direct care services to me.

5. My participation in the MCWP is entirely voluntary and I may decide to withdraw at any time and there will be no penalties or loss of other services I am entitled to. My withdrawal will not affect the availability of medical care to me at any time. Furthermore, my doctor may withdraw me from the MCWP at any time if it's in my best interest to do so.

6. I understand that I must meet all MCWP eligibility requirements, including medical needs and condition, and that if I am hospitalized I will not receive MCWP services until my discharge. If I am hospitalized for more than 30 days, I will be disenrolled from the MCWP. I also understand that I must comply with MCWP program requirements as explained to me at enrollment.

7. I agree to cooperate fully with Agency/MCWP staff and care providers and agree to refrain from any verbal or physical hostile, abusive, or threatening behavior. I understand that failure to comply with this provision may result in termination of services.

8. I have the right to ask any questions concerning the MCWP at any time. I will be informed of any significant new information pertinent to my participation. If I have any questions concerning the MCWP program, I may contact my Nurse Case Manager or Social Work Case Manager.

9. I understand that MCWP staff are mandated reporters. I also understand that as mandated reporters they have to report situations such as elder or dependent abuse, child abuse, suicidal ideations, or homicidal ideations. The reasoning for such reports, as well as examples of such instances, has been explained to me.

10. Client Initials _____ I acknowledge that I have received a copy of forms *Notice of Action (Denial/Discontinuance)* and *Request for a State Hearing*. I understand these forms will be mailed to me if my application is denied or if I am disenrolled from the MCWP.

    Client Initials_____I acknowledge that I have received a copy of the Agency Grievance Policy

    Client initials_____I acknowledge that I have received a copy of Client Rights.

I have been informed of both the home and community-based services of the MCWP and the alternative to these services and choose to receive MCWP services.

I have read and I understand the above information concerning the program. My signature indicates my agreement to participate in the program. I will be given a copy of this consent form to refer to as needed.

All questions I have concerning the MCWP at this time have been fully answered. If I have further questions, I should contact the MCWP Staff at:_____

Applicant's Signature: Date

Agency Representative: Date:

AIDS Medi-Cal Waiver Program (MCWP)
Consentimiento de Participación

Nombre del Cliente: _____# de Medi-Cal _____

Entiendo que como parte de mi aplicación para recibir servicios de Manejo de Casos, el/la Enfermero/a y el manejador de asistencia social debéra evaluar mi condición. El manejador de casos de enfermero o el manejador de asistencia social trabajador/a social será responsable de coordinar servicios en mi casa. Yo entiendo que:

1. Yo participaré en el proceso de decidir que servicios recibiré y seré notificado de los servicios y de cualquier cambio en éstos. Estos servicios se basan en la necesidad y disponibilidad de fondos. Ningún costo está relacionado con mi participación en éste programa. Sin embargo, los costos asociados con mi cuidado se cobraran a otras entidades como poliza de seguro medico, antes de cobrarlos al programa.

2. El manejador de casos de enfermeria y el manejador de asistencia social mantendrá información sobre mi progreso y diseñará un programa de servicios para mí. El tipo y la cantidad de estos servicios seran determinados por medio de sesiones individuales y de juntas de el equipo acargo de mi cuidado.

3. Entiendo que se me haran preguntas personales que incluyen; mi nombre, raza, género, salud y otra información importante. Ninguna información adquirida sera usada en contra mía ni se dará a conocer sin antes dar mi consentimiento como lo proveé la ley. Sin embargo, información general (sin ninguna clase de identificación personal) puede ser adquirida y usada en estudios o publicaciones de estos. Un certificado que obliga a los cientificos que conducen estudios a mantener la confidencialidad se mantiene en archivo. El programa de AMCWP esta compromentido a mantener la mas estricta confidencialidad.

4. La información contenida en mi expediente sera vista solamente por el personal aprobado del programa, y otras personas que están a cargo de mi cuidado o como lo específica la ley. Entiendo que mi caso pueda ser discutido en reuniones de casos, a las cuales asisten el personal del programa AMCWP, mi doctor y otras personas que me brindan servicios.

5. Mi participación en el programa de AMCWP es voluntario y yo puedo salir de el programa en cualquier momento sin represalias o pérdida de otros servicios por los cuales yo califico. Mi cuidado médico no se verá afectado por salirme del programa. Ademas, mi doctor puede darme de alta del programa si el/ella creé que es por mi bien.

6. Entiendo que necesito llenar todos los requisitos para el programa de AMCWP, los cuales incluyen necesidades y condición médica, y si llego a ser internado, yo no recibiré servicios mientras esté en el hospital. Estoy de acuerdo a seguir los reglamentos de el Programa como me lo han explicado.

7. Tengo el derecho de hacer preguntas de el programa de AMCWP en cualquier momento. Se me informará sobre cualquier cambio en el programa. Puedo manterme en contacto con mi trabajador/a de casos.

8. Estoy de acuerdo en cooperar con el personal de AMCWP y con los proveedores de cuidado. Consiento obstantemente de cualquier comportamiento hostil, ya sea verbal, abusivo, ó amenazante; al no cumplir con estos requisitos, mis servicios serán suspendidos.

9. Iniciales de el cliente_____ Yo reconosco que hé recibido copias de las siguientes formas: **"Notificación de Acción, y Petición para una Audencia con el Estado".** Tambien, estas formas se me emviaran por correo si mi aplicación para servicios al AMCWP fuése negada por mal comportamiento, por haber llegado al limite del uso al Medi-Cal, ó si mis servicios son cancelados por no calificar para el programa de AMCWP.

   Iniciales de el Cliente _____ Yo he recibido una copia de las Reglas de Quejas de la Agencia.

   Iniciales de el Cliente _____ Yo he recibido una copia de los Derechos de el Cliente

Certifico que he leido y entiendo la información aqui escrita sobre el programa. Con mi firma indico que estoy de acuerdo a participar en el programa. Se me proporcionará una copia de este acuerdo en el momento que lo necesite.

Todas las preguntas sobre el programa han sido contestadas completamente. Si tengo preguntas en el futuro, llamaré a la siguiente persona al telefono: ( ) _____-_____

Firma de el Aplicante _____ Fecha _____

Representate de la Agencia _____ Fecha _____

AIDS Case Management Program (CMP)
Certificate of Eligibility
Physician or Primary Care Practitioner

SECTION 1
IDENTIFYING INFORMATION

CLIENT'S DATE OF BIRTH:	**CLIENT'S SOCIAL SECURITY NUMBER:**

SECTION 2
HIV DISEASE/AIDS DIAGNOSIS AND TUBERCULOSIS SCREENING

DIAGNOSIS:

☐ HIV DISEASE DATE OF FIRST POSITIVE TEST FOR HIV:

☐ AIDS DATE OF AIDS DIAGNOSIS:

TUBERCULOSIS (TB) SCREENING:

HAS PATIENT BEEN SCREENED FOR TB? ☐ YES ☐ NO

TB SKIN TEST DATE: ☐ POSITIVE ☐ NEGATIVE

TB CHEST X-RAY DATE: ☐ POSITIVE ☐ NEGATIVE

IS PATIENT CURRENTLY RECEIVING PREVENTIVE TB TREATMENT: ☐ YES ☐ NO

IS PATIENT RECEIVING TREATMENT FOR ACTIVE TB: ☐ YES ☐ NO

SECTION 3
PHYSICIAN OR PRIMARY CARE PRACTITIONER
CERTIFICATION OF ELIGIBILITY

I AM THE PRIMARY CARE PRACTITIONER RESPONSIBLE FOR _____'S (CLIENT'S NAME) HIV/AIDS CARE. I CERTIFY THE ABOVE INFORMATION IS CORRECT AND BASED ON A REVIEW OF THE CLIENT'S HIV/AIDS TREATMENT NEEDS.

_____ _____

PHYSICIAN OR PRIMARY CARE PRACTITIONER SIGNATURE DATE

_____ _____

PHYSICIAN OR PRIMARY CARE PRACTITIONER NAME (PLEASE PRINT) LICENSE NUMBER

(_____)_____ _____

PHONE NUMBER STREET ADDRESS

_____ _____

CITY ZIP CODE

SECTION 4
CMP PROGRAM

_____ _____

CASE MANAGER NAME (PLEASE PRINT) PHONE

_____ _____

DATE SENT DATE RECEIVED

CLIENT NAME:	**CHART NUMBER:**

AIDS Medi-Cal Waiver Program (MCWP)
Certificate of Eligibility
Physician

SECTION 1
IDENTIFYING INFORMATION

CLIENT'S DATE OF BIRTH:	CLIENT'S SOCIAL SECURITY NUMBER:

SECTION 2
HIV DISEASE/AIDS DIAGNOSIS, OPPORTUNISTIC INFECTIONS, AND TUBERCULOSIS SCREENING

DIAGNOSIS:

☐ HIV ASYMPTOMATIC (INELIGIBLE FOR CMP/MCWP)	DATE OF FIRST POSITIVE TEST FOR HIV:
☐ HIV SYMPTOMATIC (INDICATE ALL CURRENT SYMPTOMS BELOW)	DATE OF HIV SYMPTOMATIC DIAGNOSIS:
☐ AIDS (INDICATE ALL CURRENT SYMPTOMS BELOW)	DATE OF AIDS DIAGNOSIS:

CURRENT SYMPTOMS RELATED TO HIV DISEASE, HIV DISEASE TREATMENT, OR AIDS INCLUDE:

OPPORTUNISTIC INFECTIONS:

☐ TOXO	DATE:
☐ CMV	DATE:
☐ CANDIDIASIS	DATE:
☐ PCP	DATE:
☐ MAC	DATE:
☐ KS	DATE:
☐ OTHER:	DATE:

TUBERCULOSIS (TB) SCREENING:

HAS PATIENT BEEN SCREENED FOR TB?	☐ YES ☐ NO
TB SKIN TEST DATE:	☐ POSITIVE ☐ NEGATIVE
TB CHEST X-RAY DATE:	☐ POSITIVE ☐ NEGATIVE
IS PATIENT CURRENTLY RECEIVING PREVENTIVE TB REATMENT:	☐ YES ☐ NO
IS PATIENT RECEIVING TREATMENT FOR ACTIVE TB:	☐ YES ☐ NO

SECTION 3
PHYSICIAN
CERTIFICATION OF ELIGIBILITY

I AM THE PHYSICIAN RESPONSIBLE FOR _____'S (CLIENT'S NAME) HIV/AIDS CARE. I CERTIFY THE ABOVE INFORMATION IS CORRECT AND BASED ON A REVIEW OF THE CLIENT'S HIV/AIDS TREATMENT NEEDS.

_____ _____
PHYSICIAN SIGNATURE DATE

_____ _____
PHYSICIAN NAME (PLEASE PRINT) LICENSE NUMBER

(_____)_____ _____
PHONE NUMBER STREET ADDRESS

_____ _____
CITY ZIP CODE

SECTION 4
MCWP PROGRAM

_____ _____
CASE MANAGER NAME (PLEASE PRINT) PHONE

_____ _____
DATE SENT DATE RECEIVED

CLIENT NAME:	CHART NUMBER:

CDC CLASSIFICATION SYSTEM FOR HIV IN CHILDREN UNDER 13 YEARS OF AGE

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

Diagnosis Classification of HIV Infection--Using the diagnosis classification definitions on the reverse side of this form, check (x) one box below.

	HIV Infected		Perinatally Exposed (Prefix E)		Seroreverter (SR)

Immunologic Category Definitions--Based on the CD4 count and/or percentage, determine the **immunologic category** (e.g., "1", "2", or "3").

	AGE OF CHILD					
	< 12 months		1-5 years		6-12 years	
IMMUNOLOGIC CATEGORY*	μL	(%)	μL	(%)	μL	(%)
1:No evidence of suppression	∃1,500	(∃25)	∃1,000	(∃25)	∃500	(∃25)
2:Evidence of moderate suppression	750-1,499	(15-24)	500-999	(15-24)	200-499	(15-24)
3: Severe suppression	<750	(<15)	<500	(<15)	<200	(<15)

- If the CD4+ count and the CD4+ percent indicate different classification categories, the child should be classified into the more severe category.

Pediatric Classification of HIV Infection--Using the attached **Clinical Category** definitions, determine and **circle one** clinical category below. **Add Prefix E** for perinatally exposed children until their HIV status is confirmed (e.g., $A1^{E}$).

Clinical Categories (Circle One) (See attachment)				
Immunologic Categories (see chart above)	**N: No signs/ symptoms**	**A: Mild signs/ symptoms**	**B: Moderate signs/ symptoms**	**C: Severe signs/ symptoms**
1: No evidence of suppression	N1	A1	B1	C1
2: Evidence of moderate suppression	N2	A2	B2	C2
3: Severe suppression	N3	A3	B3	C3

Tuberculosis Screening

Has patient been screened for TB?	☐ Yes ☐ No
TB skin test date:	☐ Positive ☐ Negative
TB chest x-ray date:	☐ Positive ☐ Negative
Is patient currently receiving preventive TB treatment:	☐ Yes ☐ No
Is patient receiving treatment for active TB:	☐ Yes ☐ No

I accept full professional responsibility for this client's care. This client is stable and appropriate for home care. I will work closely with the CMP/MCWP Case Managers in meeting thisclients' needs in the most appropriate manner possible.

I certify that this client requires care at the Nursing Facility Level of Care or higher. ☐**Yes** ☐ **No**

Attending Physician/Primary Care Practitioner Signature:_____

Print Name:_____ Date:_____

CLIENT NAME: **CHART NUMBER**:

CDC CLASSIFICATION SYSTEM FOR HIV IN CHILDREN UNDER 13 YEARS OF AGE

DIAGNOSIS CLASSIFICATION OF HIV INFECTION - DIAGNOSIS DEFINITIONS

Diagnosis: HIV Infected

1. A child less than 18 months of age who is known to be HIV seropositive or born to HIV-infected mother and:
   a. Has positive results on two separate determinations (excluding cord blood) from one or more of the following HIV detection tests: (1) HIV culture, (2) HIV polymerase chain reaction, (3) HIV antigen (p24)

   OR

   b. Meets criteria for AIDS diagnosis on the 1987 AIDS surveillance case definition (10).

   OR

2. A child at least 18 months of age or under 13 years of age born to an HIV-infected mother or any child infected by blood, blood products, or other known modes of transmission (e.g., sex contact) who:
   a. Is HIV anti-body positive by repeatedly reactive enzyme immunoassay (EIA) and confirmatory test (e.g., Western blot or immunofluorescence assay (IFA)

   OR

   b. Meets any of the criteria in "1.a." above.

Diagnosis: Perinatally Exposed (Prefix E)--A child who does not meet the **HIV Infected Diagnosis** criteria who:

1. Is HIV seropositive by EIA and confirmatory test (e.g., Western blot or IFA) and is less than 18 months of age at the time of test;

   OR

2. Has unknown antibody status, but was born to a mother known to be infected with HIV.

Diagnosis: Seroreverter (SR)--A child who is born to an HIV-infected mother and who:

1. Has been documented as HIV-antibody negative (i.e., two or more negative AC tests performed at 8-18 months of age or one negative EIA test after 18 months of age);

   AND

2. Has had no other laboratory evidence of infection (has not had two positive viral detection tests, if performed);

   AND

3. Has not had an AIDS-defining condition.

CLIENT NAME: **CHART NUMBER**:

CLINICAL CATEGORIES

Category N: Not Symptomatic--Children who have no signs or symptoms considered to be the result of HIV infection or who have only one of the conditions listed in Category A.

Category A: Mildly Symptomatic--Children with two or more of the conditions listed below but none of the conditions listed in Categories B and C.
*Lymphadenopathy (≥ 0.5 cm at more than two sites: bilateral = one site) *Parotitis *Hepatomegaly
*Splenomegaly *Dermatitis *Recurrent or persistent upper respiratory infection, sinusitis, or otitis media

Category B: Moderately Symptomatic--Children who have symptomatic conditions other than those listed for Category A or C that are attributed to HIV infection. Examples of conditions in clinical Category B include but are not limited to:
*Anemia (<8gm/DL), neutropenia (<1,000/mm^3), or thrombocytopenia (<100,000/mm^3) persisting ≥ 30 days
*Bacterial meningitis, pneumonia, or sepsis (single episode Candidiasis, oropharyngeal (thrush), persisting (> 2 months) in children > 6 months of age * Diarrhea, recurrent or chronic * Hepatitis
*Herpes simplex virus (HSV) stomatitis, recurrent (more than two episodes within 1 year)
*Leiomyosarcoma *Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia complex
*Nephropathy *Nocardiosis * Persistent fever (lasting > 1 month) * Toxoplasmosis, onset before 1 month of age
* Varicella, disseminated (complicated chickenpox)

Category C: Severely Symptomatic--Children who have any condition listed in the 1987 surveillance case definition for acquired Immunodeficiency syndrome, with the exception of LIP. Severe conditions included in clinical Category C for children infected with HIV:
*Serious bacterial infections, multiple or recurrent (i.e., any combination of at least two culture-confirmed infections within a 2-year period) of the following types: septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ or body cavity (excluding otitis media, superficial skin or mucosal abscesses, and indwelling catheter-related infections *Candidiasis, esophageal or pulmonary (bronchi, trachea, lungs) *Coccidioi domycosis, disseminated (at site other than or in addition to lungs or cervical or hilar lymph nodes) *Cryptococcsis, extra-pulmonary persisting > than 1 month *Cryptosporidiosis or isosporiasis with diarrhea *Cytomegalovirus disease with onset of symptoms at age > 1 month (at a site other than liver, spleen, or lymph nodes) *Encephalopathy (at least one of the following progressive findings present for at least 2 months in the absence of a concurrent illness other than HIV infection that could explain the findings): a) failure to attain or loss of develop-mental milestones or loss of intellectual ability, verified by standard developmental scale or neuropsychological tests; b) impaired brain growth or acquired microcephaly demonstrated by head circumference measurements or brain atrophy demonstrated by computerized tomography or magnetic resonance imagining (serial imagining is required for children < 2 years of age); c) acquired symmetric motor deficit manifested by two or more of the following: paresis, pathologic reflexes, ataxia, or gait disturbance Herpes simplex virus infection causing a mucocutaneous ulcer that persists for > 1 month; or bronchitis, pneumonitis, or esophagitis for any duration affecting a child > 1 month of age.
*Histoplasmosis, disseminated (at a site other than or in addition to lungs or cervical or hilar lymph nodes) *Kaposi's sarcoma *Lymphoma, primary, in brain *Lymphoma, small, noncleaved cell (Burkitt's), or immunoblastic or large cell lymphoma of B-cell or unknown immunologic phenotype *Mycobacterium tuberculosis, disseminated or extrapulmonary *Mycobacterium, other species or unidentified species, disseminated (at a site other than or in addition to lungs, skin, or cervical or hilar lymph nodes) *Pneumocystis carinii pneumonia *Salmonella nontyphoid) septicemia, recurrent * Toxoplasmosis of the brain with onset at > 1 month of age *Wasting syndrome in the absence of a concurrent illness other than HIV infection that could explain the following findings: a) persistent weight loss > 10% of baseline OR b) downward crossing of at least two of the following percentile lines on the weight-for-age chart (e.g., 95th, 75th, 50th, 25th, 5th) in a child ≥ 1 year of age OR c) < 5th percentile on weight-for-height chart on two consecutive measurements, 30 days apart PLUS a) chronic diarrhea (i.e., at least two loose stools per day for ≥ 30 days OR b) documented fever (for ≥ 30 days, intermittent or constant)

CLIENT NAME: **CHART NUMBER**:

MEDI-CAL WAIVER PROGRAM
ENROLLMENT/DISENROLLMENT FORM

TO:	**Waiver Enrollment Coordinator**	**NAME OF PERSON COMPLETING THIS FORM:**	
FAX TO:	**(916) 449-5860**	**PHONE:**	( )
		AGENCY AYD NUMBER:	**0 0 0** ☐☐☐

INSTRUCTIONS:

TO ENROLL A CLIENT

1. Print the name and phone number of the agency person completing this form in the spaces provided. Enter the last three digits of the agency's AYD Number in the space provided above.
2. Complete Section I below and FAX to the enrollment coordinator at the FAX number listed above. The enrollment coordinator will process the enrollment and will call the individual named above to issue a waiver ID number or explain why enrollment cannot be processed.

TO DISENROLL A CLIENT

1. Complete Section II on the original enrollment form and FAX to the enrollment coordinator at the FAX number listed above. Client's Social Security Number is required.

SECTION I – ENROLLMENT INFORMATION

CLIENT'S SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

SEX (M/F)	**DATE OF BIRTH (MM/DD/YYYY)**	**ENROLLMENT BEGIN DATE (MM/DD/YYYY)**
☐	☐☐ / ☐☐ / ☐☐☐☐	☐☐ / ☐☐ / ☐☐☐☐

RC (STATE USE ONLY) — **9**

LEVEL OF CARE (NOTE: Nursing facility level of care or higher must be certified by the Nurse Case Manager) — **Code** ☐

1 – Nursing Facility (not hospitalized or prior hospital status unknown)
4 – Acute (hospitalized within current calendar year)

RACE/ETHNICITY — **Code** ☐

1 – Asian/Pacific Islander
2 – Black
3 – Hispanic
4 – White (non-Hispanic)
5 – Native American
6 – Other
9 - Unknown

NURSE CASE MANAGER (Print First Initial and Last Name) ☐ _____ **PHONE NUMBER** ( )

SECTION II – DISENROLLMENT INFORMATION

CLIENT'S WAIVER ID NUMBER ☐☐☐☐☐

ENROLLMENT END DATE (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

REASON FOR DISENROLLMENT — **Code** ☐

01 – Death
02 – Annual Client Cap Exceeded
03 – Lost MediCal Eligibility
04 – Improved Health Status
06 – Client Choice
07 – Left Service Area
08 – Lost to Follow-Up
09 – Transfer to CMP, Cap Exceeded
10 – Transfer to CMP, Lost Medi-Cal Elig.
11 – Transfer to CMP, Improved Health Status
15 – Incarcerated
16 - Hospitalized
20 – Non-Compliant Client
13 - Other, Describe _____

FOR STATE USE ONLY

Completed By:	**Date:**	**Call Back Date/Time:**

AIDS Medi-Cal Waiver Program
NOTICE OF ACTION (NOA)
DENIAL/REDUCTION/TERMINATION OF AIDS MEDI-CAL WAIVER BENEFITS

Name _____ **Date of Notice** _____

Address _____ **Date Services Expire** _____

_____ **Medi-Cal I.D. #** _____

Waiver I.D. # _____

Medi-Cal regulations allow for the provision of certain AIDS Medi-Cal Waiver Program (MCWP) Home and Community-Based Services (HCBS) to persons who meet specific criteria. We have taken the following action with respect to services requested for the reasons noted:

___ 1. Denied your application or ended services for causes such as program noncompliance or personal safety of caregivers or agency staff, specifically _____.

___ 2. Denied your application or ended services because you do not meet eligibility requirements as follows:

☐ You have not submitted adequate proof of Medi-Cal eligibility, your Medi-Cal eligibility cannot be verified or you are not eligible or no longer eligible for Medi-Cal.

☐ Your medical condition and/or medical needs do not currently meet the Nursing Facility or higher level of care and/or your diagnosis of asymptomatic HIV or AIDS-related medical condition, does not meet eligibility requirements, or your "CFA score" (the Cognitive and Functional Ability Scale) on the evaluation form that is used was too high.

___ 3. Denied and/or reduced some portion of the services requested. Your medical condition and/or medical needs have improved, necessitating a change in services ordered.

___ 4. Continuing to provide HCBS to you is not cost effective (i.e., the estimated cost of providing you with those services exceeds cost guidelines set by the State).

___ 5. Cost of services provided to you has reached the $13,209 calendar year annual cost cap. No more AIDS Medi-Cal Waiver services can be provided to you this calendar year.

___ 6. The services you need are fully available to you through private insurance, Medicare, Medi-Cal, or another program.

___ 7. You no longer desire HCBS.

___ 8. Other_____

This NOA is required by Code of Federal Regulations, Title 42, Chapter IV, Subpart E, and the California Code of Regulations, Title 22, Section 51346. You have the right to ask for a State Hearing (SH) if you disagree with any MCWP action. You only have ninety (90) days to ask for a hearing. The 90 days start the day after the MCWP gave or mailed you this notice. See page 2 for your appeal rights.

Denial or termination of AIDS MCWP benefits will not affect other medical or social services you are eligible to receive through California's Medi-Cal Program or other public benefit programs.

You may reapply for AIDS MCWP benefits at a future time if you believe you have become eligible.

Please call me for further information or if you have any questions. I may be reached at (_____)_____.

Sincerely,

_____ _____

Agency Representative Agency Name

STATE HEARING NOTICE - YOUR RIGHT TO APPEAL THE "NOTICE OF ACTION"

State Hearing Instructions--If you do not agree with the action described, you may request a State Hearing before an Administrative Law Judge employed by the California Department of Social Services (CDSS). This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. Your case manager can help you request a hearing. If you decide to request a hearing, you must do so within 90 days of the date of this notice. Your benefits will only continue until the *Services Expiration Date* listed at the top of page 1 which is at least 10 days from the date of this notice. If you are currently receiving AIDS MCWP services and you request a SH before the **Date Services Expire** indicated at the top of this notice (within at least 10 days after the date of this notice), you will continue to receive services until a SH decision is made. If you are currently receiving AIDS MCWP services and you request a SH after the **Date Services Expire**, your AIDS MCWP services will stop on the **Date Services Expire**. You must verbally notify your case manager if you file an appeal within this 10-day period.

If you wish to request a SH, please complete the attached *Request for a State Hearing* form and mail it to the address listed below or call the phone number provided. You must provide all the information on the form; any information missing from the request form may delay the processing of your request. If you ask for a hearing the State Hearings Division (SHD) will set up a file. You have the right to see this file before your hearing and to get a copy of the AIDS waiver provider's written position on your case at least two days before the hearing. The SHD may give your hearing file to the California Department of Health Services and the United States Department of Health and Human Services per Welfare and Institutions Code Sections 10850 and 10950.

How to Request a State Hearing—You must either complete the attached *Request for a State Hearing* **form and mail it to:**

California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814

Or call

Toll-Free Number: (800) 952-5253
Teletypewriter (TTD) only: (800) 952-8349

"Your Rights" Pamphlet Available--"Your Rights under California Welfare Programs" pamphlet issued by CDSS, provides useful information about State Hearings. This pamphlet will be sent to you when your hearing request is processed.

Authorized Representative--You can represent yourself at the State Hearing or be represented by a friend, attorney, or any other person; but, you are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit (PIAR) at (800) 952-5253.

The PIAR office can also provide further information about your hearing rights. Assistance is available in languages other than English, including Spanish.

Code of Federal Regulations, Title 42, Section 431.220, Subpart E, Chapter IV, and the California Code of Regulations, Title 22, Section 51014.1, require that this **Notice of Action/State Hearing Notice** be mailed at time of denial of an application when it is determined that you are not eligible for waiver services or at time of reduction or termination of existing services. The Notice must be mailed **at least 10 calendar days** (excluding the mailing date) before the effective date of reduction or termination of services.

REQUEST FOR A STATE HEARING

Name	**Medi-Cal I.D. Number**
Address	**City**

I am requesting a State Hearing because of Medi-Cal related action by _____, an AIDS Medi-Cal Waiver agency related to the following reason(s):

- ❑ Denial of my application or ending of services for causes such as noncompliance or personal safety of caregivers or agency staff **OR**
- ❑ Denial of my application or ending of services because I do not meet eligibility requirements **OR**
- ❑ Denial and/or reduction of some portion of the service(s) requested **OR**
- ❑ Ending of services because it is no longer cost effective to do so **OR**
- ❑ The costs of services provided have reached the $13,209 calendar year annual cost cap **OR**
- ❑ Denial of my application or ending of services because services I need are fully available through private insurance, Medicare, Medi-Cal, or another program **OR**
- ❑ I no longer desire Home and Community Based services.
- ❑ Other_____

Describe the basis for your appeal below:

_____

_____

_____

- ❑ I speak a language other than English and need an interpreter for my hearing. (The State will provide the interpreter at no cost to you.)

Language:	Dialect:

- ❑ I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person can be a friend or relative but cannot interpret for you.)

Name: _____ Phone Number:_____

Street Address: _____

City: _____State_____ Zip Code_____

Signature: **Date:**

Mail to: California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814
Toll-Free Number: (800) 952-5253
Teletypewriter (TTD) only: (800) 952-8349

The AIDS Medi-Cal Waiver Program is administered by the Community Based Care Section, Office of AIDS, Department of Health Services, MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.

Programa de Exención para Personas con el Síndrome de Inmunodeficiencia Adquirida (SIDA)
bajo el Programa de Asistencia Médica de California (Medi-Cal)
NOTIFICACION DE ACCION (NOA)
NEGACION/REDUCCION/DESCONTINUACION DE LOS BENEFICIOS DE ESTE PROGRAMA

Nombre _____ **Fecha de la notificación** _____

Dirección _____ **Medi-Cal - # de identificación** _____

_____ **Exención - # de identificación** _____

Fecha en que los servicios se descontinuarán _____

Los reglamentos de Medi-Cal permiten que se proporcionen ciertos servicios de casa y servicios basados en la comunidad (HCBS) a través del Programa de Exención bajo el Programa de Medi-Cal (MCWP) para Personas con SIDA si estas personas cumplen con los requisitos específicos. En relación a los servicios que se solicitaron, hemos tomado la siguiente acción debido a las razones indicadas:

___ 1. Negamos su solicitud o descontinuamos sus servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, específicamente
_____.

___ 2. Negamos su solicitud o descontinuamos sus servicios debido a que usted no cumple con los requisitos de elegibilidad como se indica a continuación:

☐ Usted no ha presentado las pruebas adecuadas de elegibilidad para Medi-Cal, su elegibilidad para Medi-Cal no se puede verificar, o no es o ha dejado de ser elegible para Medi-Cal.

☐ Actualmente, su condición médica y/o sus necesidades médicas no cumplen con los requisitos para el cuidado en un establecimiento de cuidado médico continuo no intenso o a un nivel más alto y/o el diagnóstico de que usted tiene el virus de inmunodeficiencia humana (VIH) o SIDA sin presentar síntomas no cumple con los requisitos de elegibilidad, o su clasificación en la evaluación que se utiliza (la tabla de habilidad cognoscitiva y habilidad para funcionar) fue demasiado baja.

___ 3. Negamos y/o redujimos una porción de los servicios que se solicitaron. Su condición médica y/o sus necesidades médicas han mejorado lo cual ocasionó un cambio en los servicios que se ordenaron.

___ 4. El continuar proporcionándole los servicios HCBS ya no es lo más económico (es decir, el costo calculado para proporcionarle a usted esos servicios es más que las normas de costo establecidas por el Estado).

___ 5. El costo de los servicios que se le han proporcionado ha alcanzado los $13,209 que es lo máximo permitido anualmente para un año civil. Para este año civil, ya no puede recibir más servicios bajo el MCWP para Personas con SIDA.

___ 6. Los servicios que usted necesita están completamente disponibles a través de su seguro privado, Medicare (seguro médico federal), Medi-Cal, u otro programa.

___ 7. Usted ya no quiere los servicios HCBS.

___ 8. Otra razón: _____

Esta notificación de acción es un requisito del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y el Código de Ordenamientos de California, Título 22, Sección 51346. Usted tiene derecho a solicitar una audiencia con el estado (SH) si usted no está de acuerdo con alguna acción en relación al MCWP. Tiene solamente noventa (90) días para solicitar una audiencia. Los 90 días empezaron a contar al siguiente día de cuando el MCWP le dio o le envió por correo esta notificación. Para los derechos que tiene para apelar, vea la página 2.

La negación o descontinuación de los beneficios del MCWP para Personas con SIDA no afectará otros servicios médicos o sociales para los cuales usted es elegible bajo el Programa de Medi-Cal u otros programas de beneficios públicos.

En el futuro, puede volver a solicitar los beneficios del MCWP para Personas con SIDA si usted cree que ya es elegible.

Para más información o si tiene alguna pregunta, por favor llámeme. Mi número de teléfono es (____)_____.

Atentamente.

_____ _____
Representante de la agencia/oficina Nombre de la agencia/oficina

NOTIFICACION DE UNA AUDIENCIA CON EL ESTADO - SU DERECHO A APELAR LA "NOTIFICACION DE ACCION"

Instrucciones en relación a una audiencia con el estado--Si usted no está de acuerdo con la acción descrita, usted puede solicitar una audiencia con el estado ante un juez de leyes administrativas empleado por el Departamento de Servicios Sociales de California (CDSS). Esta audiencia se llevará a cabo en una manera informal para asegurar que todas las personas presentes puedan hablar libremente. La persona encargada de su caso puede ayudarle a solicitar una audiencia. Si usted decide solicitar una audiencia, tiene que hacerlo antes de que pasen 90 días a partir de la fecha de esta notificación. Sus beneficios solamente continuarán hasta la "**Fecha en que los beneficios se descontinuarán**" que aparece en la parte de arriba de la página 1, la cual es al menos 10 días después de la fecha de esta notificación. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado antes de la "**Fecha en que los beneficios se descontinuarán**" anotada en la parte de arriba de esta notificación (al menos 10 días después de la fecha de esta notificación), usted continuará recibiendo los servicios hasta que se emita la decisión de la audiencia con el estado. Si actualmente está recibiendo servicios bajo el MCWP para Personas con SIDA y usted solicita una audiencia con el estado después de la "**Fecha en que los beneficios se descontinuarán**", los servicios se descontinuarán en dicha fecha. Si usted presenta una apelación antes que se termine el período de 10 días, tiene que notificarle verbalmente al trabajador encargado de su caso.

Si desea solicitar una audiencia con el estado, por favor complete el formulario de "Petición para una audiencia con el estado" adjunto y envíelo por correo a la dirección que aparece abajo o llame al número de teléfono que se proporciona. Usted tiene que proporcionar toda la información en el formulario; cualquier información que falte en el formulario pudiera atrasar la tramitación de su petición para una audiencia con el estado. Si usted solicita una audiencia, la División de Audiencias Administrativas preparará un expediente. Al menos dos días antes de su audiencia, usted tiene derecho a ver su expediente y a recibir una copia escrita de la declaración de posición sobre su caso del proveedor de la exención para las personas con SIDA. De acuerdo a lo estipulado en las Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones, la División de Audiencias Administrativas puede darle su expediente de la audiencia al Departamento de Servicios de Salud de California y al Departamento de Servicios de Salud y Servicios Humanos de los Estados Unidos.

Cómo solicitar una audiencia con el estado—Usted puede completar el formulario de "Petición para una audiencia con el estado" adjunto y enviarlo por correo al Departamento de Servicios Sociales de California (CDSS) a la siguiente dirección:

California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814

o puede llamar al
Número de teléfono gratuito: (800) 952-5253
Teletipo (TTY) solamente: (800) 952-8349

Folleto disponible acerca de sus derechos--El folleto "Sus derechos bajo los programas de asistencia pública de California" publicado por el CDSS le proporciona información útil acerca de las audiencias con el estado. Le enviarán este folleto una vez que se tramite su petición para una audiencia.

Representante autorizado--En la audiencia con el estado, se puede representar a sí mismo o puede ser representado por un amigo, abogado, o cualquier otra persona; pero, usted tiene que hacer los arreglos para tener a un representante. Puede obtener ayuda para localizar asesoramiento legal sin costo llamando al número de teléfono gratuito de la Oficina de Preguntas y Respuestas al Público (PIAR) al (800) 952-5253.

La Oficina de PIAR también le puede proporcionar más información acerca de sus derechos en relación a una audiencia. Esta información se proporciona en varios idiomas aparte del inglés, incluyendo el español.

La Sección 431.220 del Código de Ordenamientos Federales, Título 42, Capítulo IV, Subparte E, y la Sección 51014.1 del Código de Ordenamientos de California, Título 22, estipulan que esta **Notificación de acción/Notificación de una audiencia con el estado** se tiene que enviar por correo cuando se niegue una solicitud debido a que se determinó que usted ya no es elegible para los servicios bajo una exención o cuando se reduzcan o descontinúen los servicios actuales. La notificación se tiene que enviar por correo **al menos 10 días consecutivos** (excluyendo la fecha en que se envió) antes de la fecha en que entre en vigor la reducción o descontinuación de los servicios.

PETICION PARA UNA AUDIENCIA CON EL ESTADO

Nombre	**Número de identificación de Medi-Cal**
Dirección	**Ciudad**

Estoy solicitando una audiencia con el estado debido a una acción relacionada a Medi-Cal que tomó _____, una agencia/oficina que proporciona exenciones para personas con SIDA para el Programa de Medi-Cal. El motivo (o motivos) aparece a continuación:

- Negación de mi solicitud o descontinuación de los servicios debido a motivos tales como la falta de cumplimiento con los requisitos del programa o problemas en relación a la seguridad personal de los proveedores de cuidado o del personal de la agencia/oficina, **o**
- Negación de mi solicitud o descontinuación de los servicios debido a que no cumplo con los requisitos de elegibilidad, **o**
- Negación y/o reducción de una porción de los servicios solicitados, **o**
- Descontinuación de los servicios debido a que el proporcionar los servicios ya no es lo más económico o porque el costo de los servicios proporcionados ha alcanzado los $13,209 que es lo máximo permitido anualmente para un año civil.
- Negación de mi solicitud o descontinuación de los servicios debido a que los servicios que necesito están completamente disponibles a través de un seguro privado, Medicare (seguro médico federal), Medi-Cal, u otro programa o debido a que yo ya no quiero los servicios de casa y basados en la comunidad.
- Otro motivo: _____

Describa a continuación en que se basa su apelación:

_____

_____

_____

- Hablo otro idioma que no es el inglés y necesito un intérprete para mi audiencia. (El Estado le proporcionará un intérprete sin costo para usted.)

Idioma:	Dialecto:

- Quiero que la persona cuyo nombre aparece a continuación me represente en esta audiencia. Otorgo el permiso para que esta persona vea mis expedientes o asista a la audiencia en mi nombre. (Esta persona puede ser un amigo o pariente pero no puede ser su intérprete.)

Nombre: _____ Número de teléfono:_____

Domicilio: _____

Ciudad: _____ Estado _____ Código postal _____

Firma:

Envíe por correo a: California Department of Social Services
State Hearings Division
MS-19-37
744 P Street
Sacramento, CA 95814
Número de teléfono gratuito: (800) 952-5253
Teletipo (TTY) solamente: (800) 952-8349

El Programa de Exención para Personas con SIDA bajo el Programa de Medi-Cal es administrado por la Sección del Cuidado Basado en la Comunidad en la Oficina del SIDA en el Departamento de Servicios de Salud; la dirección y número de teléfono son: *AIDS Medi-Cal Waiver Program, Community Based Care Section, Office of AIDS, Department of Health Services, MS 7700, P.O. Box 997426, Sacramento, CA 95899-7426, (916) 449-5900.*

AIDS MEDI-CAL WAIVER PROGRAM
NURSING FACILITY LEVEL OF CARE (NFLOC)
Effective May 1997

To qualify for Nursing Facility care services, the complexity of the client's medical problems is such that he or she needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Nursing Facility care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual client independence to the extent of his or her ability. Use the following description as a guide for determining appropriate placement:

1. Medications may be mainly supportive or stabilizing but still require professional nurse observation for response and effect on an intermittent basis.

2. Diet may be of a special type; clients may need assistance in feeding him/herself.

3. The client may require assistance or supervision in personal care, such as in bathing or dressing.

4. The client may need encouragement in restorative measures for increasing and strengthening his or her functional capacity to work toward greater independence.

5. The client may have some degree of vision, hearing or sensory loss.

6. The client may have limitation in movement.

7. The client may be incontinent of urine and/or bowels.

8. The client may exhibit some mild confusion or depression; however, his or her behavior must be stabilized to such an extent that it poses no threat to him/herself or others.

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Client Name _____ **Chart Number** _____

Social Security Number _____-_____-_____ **Birth Date** _____/_____/_____

Provider Name/ Address _____

_____

_____

_____

I, _____, hereby authorize the above-named healthcare provider to furnish and/or receive pertinent medical **(specifically, records relating to my HIV/AIDS status)** and social services records and documents relating to my medical history, my mental and physical condition, services rendered and all treatment provided to me, to:

Program Name/ Address _____

_____

_____

_____

I understand that as part of my application for services through _____, my medical condition must be evaluated to determine eligibility for case management and provide ongoing case management and related services. Information released pursuant to this authorization will be used solely for the purpose of administering this program.

Additionally, I hereby authorize _____ to fax information to the State Office of AIDS.

This authorization is **effective today**, and shall remain in effect until such time as I revoke it in writing or until **two years from the date signed**.

I understand that I have a right to receive a copy of this authorization.

Signed _____ **Date** _____
(Client/Legal Representative)

If signed by other than the client, indicate relationship

_____

AUTORIZACIÓN PARA COMPARTIR INFORMACIÓN CONFIDENCIAL

Nombre del Cliente:_____ Número del Archivo:_____

Número de Seguro Social:_____ Fecha de Nacimiento:_____

Nombre y Dirección
Del Proveedor Médico _____

_____

_____

Yo,_____, por medio de la presente, autorizo al proveedor de salud arriba mencionado a presentar información pertinente a mis servicios médicos y sociales, al igual que documentos relacionados con mi historial médico, mi condición física y mental, servicios y todos los tratamientos provistos hacia mi persona, a:

Nombre y Dirección
Del Programa _____

_____

_____

Específicamente, yo autorizo a compartir mi historial médico relacionado con mi estado de VIH/SIDA. Iniciales del cliente:_____.

Yo entiendo que, como parte del proceso de mi solicitud para servicios a travéz de_____ _____, mi condición médica debe de ser evaluada para determinar mi eligibilidad para manejamiento de casos y servicios relacionados. La información revelada por ésta autorización será utilizada solamente con el propósito de administración del programa. Tambien le autorizo a _____ que mande informacion por fax a la Oficina Del SIDA Del Estado.

Esta autorización es **efectiva hoy mismo** y se mantendrá vigente hasta la fecha en que yo mismo la revoque por escrito, ó **dos años depues de la fecha de hoy**.

Yo entiendo que tengo el derecho a recibir una copia de ésta autorización.

Firma_____ **Fecha**_____
(Cliente / Representante Legal)

Si ha sido firmado por otra persona, indique la relación_____

AIDS CASE MANAGEMENT
AND
AIDS MEDI-CAL WAIVER PROGRAMS

CLIENT RIGHTS IN CASE MANAGEMENT

Case Management should observe the following rights for all clients:

The right to be given a fair and comprehensive assessment of his or her health, functional, psychosocial and cognitive ability.

The right to have access to needed health and social services for which he or she is eligible.

The right to be treated with respect and dignity.

The right to self-determination, including the opportunity to participate in developing one's plan for services.

The right to be notified of any changes of services, termination of service, or discharge from the program.

The right to withdraw from the case management program any time.

The right to a grievance procedure in the event that the client feels his or her rights have been violated, or perceives discrimination or inappropriate treatment.

I have explained the CMP/MCWP and the involvement requested of the client. I have explained the rights of the client for case management services. I have answered questions about the CMP/MCWP asked by the client, or by a responsible concerned persons on behalf of the client, and I have provided a copy of this form to the client.

Client Signature:_____ Date:_____

Staff Signature:_____ Date: _____

CMP/MCWP POLICIES & PROCEDURES

Derechos del Cliente en el Manejo de Casos

El Manejo de Casos asegurará los siguientes derechos de los clientes registrados en el programa.

El derecho de tener un asesoramiento integral de salud, abilidades funcionales, psicológicas y cognitivas.

El derecho de tender accesso a servicios médicos y sociales por los cuales esta elegible.

El derecho de ser tratado con respeto y dignidad.

El derecho de auto-determinación, incluyendo tener la oportunidad de participar en el desarrollo de el plan de servicio.

El derecho de ser notificado de cualquier cambio en servicios, terminacion de servicios o suspención del programa.

El derecho de terminar mi participación en el programa de manejo de casos en cualquier momento.

El derecho a un Procedimiento de Quejas en caso que piense que mis derechos hayan sido violados, o en caso de discriminación o de haber recibido mal tratamiento.

Los derechos de los clientes han sido explicados. Le he explicado al cliente sus derechos sobre los servicios de manejo de casos. He respondido a las preguntas sobre CMP o AMCWP que ha hecho el cliente, y/o la persona al cuidado del cliente. El cliente ha recibido una copia de esta forma.

Mi firma asegura que he recibido una copia de esta forma.

_____ _____
Firma de el Cliente Fecha

_____ _____
Firma de el Trabajador/a de CMP Fecha

AIDS CMP/MCWP
Transfer Log

HISTORY		
ENROLLMENT DATE: DISENROLLMENT DATE:	☐ CMP ☐ MCWP	CLIENT SIGNED AGREEMENT TO PARTICIPATE: ☐ YES ☐ NO
ENROLLMENT DATE: DISENROLLMENT DATE:	☐ CMP ☐ MCWP	CLIENT SIGNED AGREEMENT TO PARTICIPATE: ☐ YES ☐ NO
ENROLLMENT DATE: DISENROLLMENT DATE:	☐ CMP ☐ MCWP	CLIENT SIGNED AGREEMENT TO PARTICIPATE: ☐ YES ☐ NO
ENROLLMENT DATE: DISENROLLMENT DATE:	☐ CMP ☐ MCWP	CLIENT SIGNED AGREEMENT TO PARTICIPATE: ☐ YES ☐ NO
ENROLLMENT DATE: DISENROLLMENT DATE:	☐ CMP ☐ MCWP	CLIENT SIGNED AGREEMENT TO PARTICIPATE: ☐ YES ☐ NO

CLIENT NAME:	**CHART NUMBER:**

Form	Number	Revision Date	Type
Initial Nursing Assessment	CMP/MCWP 4*	3/06	Sample
Medication Sheet	CMP/MCWP 4* Attachment	4/05	Sample
Cognitive and Functional Ability Scale	CMP/MCWP 5	10/05	Sample
Initial Psychosocial Assessment	CMP/MCWP 7*	3/06	Sample
Resource Evaluation Assessment / Reassessment	CMP/MCWP 8*	4/05	Sample
Home Environment Assessment / Reassessment	CMP/MCWP 9*	3/06	Sample

Mandatory Forms: must be used "as is"; no changes may be made to these forms.
Sample Forms: may be revised to meet an individual contractor's needs but must contain all of the elements within the forms. Forms can be identified as either sample or mandatory by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (S) for sample forms or (M) for mandatory forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

* These are fill-and-print forms.

COGNITIVE AND FUNCTIONAL ABILITY SCALE FOR PERSONS WITH HIV DISEASE/AIDS--DEFINITIONS

1. **NUTRITION**

INDEPENDENT - Able to do all meal planning, shopping, and preparation.	11
MINIMAL ASSISTANCE - Knowledge deficit or needs assistance with planning or shopping.	7
MODERATE ASSISTANCE Home delivered meals, needs assistance with meal preparation, or physiological impairment such as nausea, vomiting, weight loss or malnourishment.	5
CONSIDERABLE ASSISTANCE Alternative or artificial therapy including tube feedings, or must be fed by others.	3
TOTALLY DEPENDENT IV fluids or TPN only or no intake.	1

2. **HYGIENE**

INDEPENDENT Able to perform personal hygiene and dressing without assistance.	11
MINIMAL ASSISTANCE Tires easily, needs adaptive devices, and/or supervision.	7
MODERATE ASSISTANCE Able to perform personal hygiene and dressing with assistance of one person.	5
CONSIDERABLE ASSISTANCE Assistance with entire bath and dressing. Cannot stand independently.	3
TOTALLY DEPENDENT Bed bath only. Does not or should not be dressed.	1

3. **EXCRETION**

INDEPENDENT Fully continent. Up to bathroom alone. Able to complete all toileting functions without assistance.	11
MINIMAL ASSISTANCE Continent with assistance. Tires easily.	7
MODERATE ASSISTANCE Stress or occasional incontinence. May need some assistance or adaptive device.	5
CONSIDERABLE ASSISTANCE Frequent incontinence. Needs adaptive devices and assistance.	3
TOTALLY DEPENDENT No bowel or bladder control. Needs maximum assistance.	1

4. **ACTIVITY**

INDEPENDENT	11
No physical limitations.	
MINIMAL ASSISTANCE	7
Ambulates independently but requires frequent rest and/or adaptive devices. Tires easily.	
MODERATE ASSISTANCE	5
Unable to ambulate without assistance and/or adaptive devices. Unsteady gait.	
CONSIDERABLE ASSISTANCE	3
Unable to ambulate or falls frequently.	
TOTALLY DEPENDENT	1
Bedridden. Unable to move self in bed. Cannot transfer self.	

5. **TREATMENTS/MEDICATIONS**

INDEPENDENT	11
No or self-administered medications. Able to access medical services without assistance.	
MINIMAL ASSISTANCE	7
Self-administers medications/treatments and requires intermittent instruction and observation. May need reminder to take medications.	
MODERATE ASSISTANCE	5
Administration requires supervision and/or assistance.	
CONSIDERABLE ASSISTANCE	3
Frequent administration of medications/treatments with maximum assistance.	
TOTALLY DEPENDENT	1
No self-administration. Comfort measures only.	

6. **TEACHING**

INDEPENDENT	11
Able to obtain and understand information independently.	
MINIMAL ASSISTANCE	7
Knowledge deficit. Guidance needed in accessing information and resources.	
MODERATE ASSISTANCE	5
Moderate teaching required with ongoing reinforcement.	
CONSIDERABLE ASSISTANCE	3
Detailed in-depth teaching required. Communication barriers/ sensory defects.	
TOTALLY DEPENDENT	1
Unresponsive.	

7. **SUPPORT SYSTEMS**

INDEPENDENT	11
Independently accesses available support systems.	
MINIMAL ASSISTANCE	7
Guidance needed in accessing available support systems.	
MODERATE ASSISTANCE	5
Some support systems in place. Occasional intervention.	
CONSIDERABLE ASSISTANCE	3
Limited resources available. Ongoing assistance required accessing support systems. More than one HIV-infected household member.	
TOTALLY DEPENDENT	1
No identifiable support systems.	

8. **MENTAL STATUS**

INDEPENDENT	11
Alert and oriented.	
MINIMAL ASSISTANCE	7
Deficit in concentration, thought process, memory and/or insight.	
MODERATE ASSISTANCE	5
Substantial deficit in concentration, thought process, memory and/or insight requiring supervision and/or assistance. Safety risk.	
CONSIDERABLE ASSISTANCE	3
Responses minimal. Disabling dementia or other psychiatric diagnosis.	
TOTALLY DEPENDENT	1
Unresponsive.	

9. **BEHAVIOR**

INDEPENDENT	11
Self-directed, cooperative, active in decision-making.	
MINIMAL ASSISTANCE	7
Socially appropriate. May require encouragement to initiate interactions but follows through.	
MODERATE ASSISTANCE	5
Passive, resistant, or poor compliance. Requires continuous encouragement to follow through.	
CONSIDERABLE ASSISTANCE	3
Non-compliant. Unpredictable, socially inappropriate.	
TOTALLY DEPENDENT	1
Unresponsive.	

AIDS CMP/MCWP
Initial
Nursing
Assessment

SECTION 1
IDENTIFYING INFORMATION

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

HIV STATUS/DATE OF DIAGNOSIS:	**MODE OF TRANSMISSION**:
ADDRESS: STREET CITY ZIP CODE MAIL OK? ☐YES ☐ NO	**DATE OF ASSESSMENT**:
PHONE: IS IT OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	**LOCATION OF ASSESSMENT**:
CLIENT SSN:	**GENDER**: ☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ FEMALE-TO-MALE ☐ MALE-TO-FEMALE
DOB:	**AGE**:
SEXUAL ORIENTATION: ☐ HOMOSEXUAL ☐ HETEROSEXUAL ☐ BISEXUAL ☐ UNKNOWN	**RELATIONSHIP STATUS**: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ DOMESTIC PARTNER ☐ SIGNIFICANT OTHER NAME:
PRIMARY LANGUAGE:	**RACE**: **ETHNICITY**: **CULTURAL ISSUES**:
RELIGIOUS/SPIRITUAL PREFERENCE:	
EMERGENCY CONTACT: **PRIMARY:** NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: ☐ YES ☐ NO OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO	**SECONDARY:** NAME: RELATIONSHIP: PHONE: AWARE OF STATUS: ☐ YES ☐ NO OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO
WHAT OTHER AGENCIES ARE ASSISTING YOU?	

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
Initial
Nursing
Assessment

SECTION 2
HEALTH HISTORY

MEDICAL HISTORY OBTAINED FROM:
☐ CLIENT
☐ OTHER (SPECIFY):

HIV DISEASE HISTORY:
HIV+ DIAGNOSIS DATE:
MOST RECENT CD4 COUNT:
LOWEST CD4 COUNT:
HIGHEST CD4 COUNT:
AIDS DIAGNOSIS DATE:
MOST RECENT VIRAL LOAD:
LOWEST VIRAL LOAD:
HIGHEST VIRAL LOAD:

TUBERCULOSIS HISTORY:
LATEST TST RESULTS: DATE:
LATEST CXR RESULTS: DATE:
PROPHYLACTIC TREATMENT: ☐ YES ☐ NO

ALLERGIES:
☐ NO KNOWN ALLERGIES
☐ MEDICATION
☐ FOOD
☐ ENVIRONMENT
COMMENTS:

HISTORY OF THE FOLLOWING: (CHECK ALL THAT APPLY)
☐ AIDS DEMENTIA
☐ BACTERIAL PNEUMONIA
☐ CANDIDIASIS (ESOPHAGEAL, ORAL, VAGINAL)
☐ CERVICAL CANCER
☐ CRYPTOCOCCAL INFECTION
☐ COCCI
☐ CMV
☐ CMV RETINITIS
☐ ENCEPHALITIS
☐ HISTOPLASMOSIS
☐ HEPATITIS A, B, C
☐ KAPOSI'S SARCOMA
☐ ISOSPORIASIS
☐ LYMPHOMA
☐ HERPES
☐ MAC
☐ PCP
☐ TOXOPLASMOSIS
☐ STD'S
☐ WASTING
☐ TUBERCULOSIS
☐ OTHER:
COMMENTS:

OTHER HEALTH HISTORY: (CHECK ALL THAT APPLY)
☐ ALCOHOL USE
☐ ASTHMA
☐ BLEEDING DISORDER
☐ CANCER
☐ CARDIAC
☐ COPD
☐ DIABETES
☐ ELEVATED CHOLESTEROL
☐ RECREATIONAL DRUG USE
☐ GI
☐ HTN
☐ MENTAL HEALTH
☐ RENAL
☐ RESPIRATORY
☐ TOBACCO USE (PPD)
☐ SEIZURES
☐ OTHER
COMMENTS:

CHILDHOOD DISEASES/IMMUNIZATION HISTORY:

DISEASE:	AGE OR YEAR INFECTED: OR YEAR IMMUNIZED:	CHECK IF NEITHER:
CHICKEN POX:		☐
MUMPS:		☐
MEASLES:		☐
RUBELLA:		☐
TETANUS:		☐
FLU:		☐
PNEUMONIA:		☐
HEPATITIS A:		☐
HEPATITIS B:		☐
HIB:		☐
OTHER:		☐

RECENT HIV RELATED EMERGENCY ROOM VISITS/HOSPITALIZATIONS: ☐ YES ☐ NO
REASON:
LOCATIONS:
COMMENTS:
DATE:
LENGTH OF STAY:

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
Initial
Nursing
Assessment

SECTION 3
SEXUAL HISTORY

FEMALE:

SEXUALLY ACTIVE: ☐ YES ☐ NO

USES SAFE SEX PRACTICES: ☐ YES ☐ NO
(REQUIRES DISCUSSION WITH CLIENT)

BIRTH CONTROL: ☐ YES ☐ NO
METHOD:

LAST MENSTRUAL PERIOD: DATE:

CURRENTLY PREGNANT: ☐ YES ☐ NO
PLANS TO CONTINUE PREGNANCY ☐ YES ☐ NO
PLANS TO TERMINATE PREGNANCY ☐ YES ☐ NO
UNDECIDED ☐ YES ☐ NO

NUMBER OF PREGNANCIES:
NUMBER OF LIVE BIRTHS:
NO LIVE BIRTHS:

UNDERSTANDS TREATMENT OPTIONS FOR VERTICAL TRANSMISSION RISK REDUCTION ☐ YES ☐ NO

DATE OF LAST PAP:
RESULTS OF LAST PAP: ☐ NORMAL ☐ ABNORMAL
HISTORY OF ABNORMAL PAP ☐ YES ☐ NO

PERFORMS SBE MONTHLY: ☐ YES ☐ NO

DATE OF LAST MAMMOGRAM:
RESULTS OF MAMMOGRAM: ☐ NORMAL ☐ ABNORMAL

VAGINAL BURNING, ITCHING, DISCHARGE ☐ YES ☐ NO
COMMENTS:

MALE:

SEXUALLY ACTIVE: ☐ YES ☐ NO

USES SAFE SEX PRACTICES: ☐ YES ☐ NO
(REQUIRES DISCUSSION WITH CLIENT)

PROSTATE DISORDER: ☐ YES ☐ NO

LAST RECTAL/PROSTATE EXAM:
RESULTS OF RECTAL/PROSTATE EXAM: ☐ NORMAL ☐ ABNORMAL

LAST PSA TEST:
RESULTS OF PSA TEST: ☐ NORMAL ☐ ABNORMAL

PERFORMS SELF TESTICULAR EXAM MONTHLY: ☐ YES ☐ NO
COMMENTS:

SECTION 4
SERVICE PROVIDERS

PRIMARY MEDICAL PROVIDER:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

PHARMACY:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

DENTIST:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

OTHER PROVIDERS:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

CLIENT NAME: **CHART NUMBER**:

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SECTION 5
SYSTEMS REVIEW

GENERAL APPEARANCE:

CHIEF COMPLAINT:

CLIENT'S PERCEPTION OF ILLNESS:

VITAL SIGNS AS INDICATED:
TEMPERATURE:
BLOOD PRESSURE:
PULSE:
RESPIRATIONS:

HEAD AND NECK: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ HEADACHES
☐ MASSES/NODES
COMMENTS/SEVERITY/FREQUENCY:

EYES: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ VISUAL CHANGE
☐ FLOATERS
☐ ITCHING/DISCHARGE
☐ REDNESS
☐ GLASSES/CONTACTS
☐ BLIND R/L
☐ BLURRED VISION
☐ LIGHT FLASHES
☐ GLAUCOMA
☐ PERRLA
COMMENTS/SEVERITY/FREQUENCY:

EARS/NOSE: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ TINNITUS
☐ DEAF R/L
☐ HARD OF HEARING R/L
☐ DRAINAGE
☐ REDNESS
COMMENTS/SEVERITY/FREQUENCY:

MOUTH/THROAT: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ BLEEDING GUMS
☐ ORAL LESIONS
☐ CANDIDIASIS
☐ DIFFICULTY SWALLOWING
☐ WHITE PLAQUES
☐ VESICLE
☐ HOARSENESS
COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

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SECTION 5
SYSTEMS REVIEW (CONT'D)

CARDIAC/CIRCULATORY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ RATE/RHYTHM
- ☐ ORTHOPNEA
- ☐ DYSPNEA ON EXERTION
- ☐ PAROXYSMAL NOCTURNAL DYSPNEA
- ☐ CHEST PAIN (DESCRIBE)
- ☐ EDEMA
- ☐ PERIPHERAL PULSES
- ☐ ASCITES
- ☐ LIPID PANEL

COMMENTS/SEVERITY/FREQUENCY:

SKIN: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ WARM
- ☐ DRY
- ☐ MOIST
- ☐ COLOR
- ☐ POOR TURGOR
- ☐ LESIONS (LOCATION, SIZE, DRAINAGE)
- ☐ KS LESIONS
- ☐ VESICLES
- ☐ BRUISING
- ☐ ITCHING
- ☐ RASH
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ PETECHIAE

COMMENTS/SEVERITY/FREQUENCY:

RESPIRATORY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ RATE/RHYTHM
- ☐ APNEA
- ☐ DYSPNEA AT REST
- ☐ TACHYPNEA
- ☐ BREATH SOUNDS (DESCRIBE)
- ☐ NON-PRODUCTIVE COUGH
- ☐ PRODUCTIVE COUGH
- ☐ SOB AT REST
- ☐ DYSPNEA ON EXERTION
- ☐ OXYGEN
- ☐ CYANOSIS

COMMENTS/SEVERITY/FREQUENCY:

GASTROINTESTINAL: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ ABDOMINAL DISTENTION
- ☐ CONSTIPATION
- ☐ CRAMPING
- ☐ BLOODY STOOLS
- ☐ FLATULENCE
- ☐ DIARRHEA
- ☐ NAUSEA/VOMITING
- ☐ HEARTBURN
- ☐ INCONTINENCE

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
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SECTION 5
SYSTEMS REVIEW (CONT'D)

GENITOURINARY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ FREQUENCY
- ☐ URGENCY
- ☐ DYSURIA
- ☐ HEMATURIA
- ☐ LESION
- ☐ BURNING
- ☐ INCONTINENCE
- ☐ INFLAMMATION
- ☐ DISCHARGE/DRAINAGE

FEMALE:
- ☐ CANDIDIASIS
- ☐ VAGINAL DISCHARGE
- ☐ DYSMENORRHEA
- ☐ ABNORMAL BLEEDING

COMMENTS/SEVERITY/FREQUENCY:

ENDOCRINE: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ FATIGUE
- ☐ IRRITABILITY
- ☐ MENTAL STATUS CHANGES
- ☐ WEIGHT CHANGE
- ☐ OBESITY
- ☐ BLOD SUGAR LEVELS

COMMENTS/SEVERITY/FREQUENCY:

CENTRAL NERVOUS SYSTEM: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ SEIZURES
- ☐ BEHAVIORAL CHANGES
- ☐ DELUSIONS
- ☐ APHASIA
- ☐ FINE MOTOR CHANGES
- ☐ TREMORS
- ☐ SYNCOPE
- ☐ MEMORY LOSS
- ☐ IMPAIRED DECISION MAKING
- ☐ HALLUCINATIONS
- ☐ ATAXIA
- ☐ GROSS MOTOR CHANGE
- ☐ SLURRED SPEECH
- ☐ VERTIGO

COMMENTS/SEVERITY/FREQUENCY:

MUSCULOSKELETAL: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ ATAXIA
- ☐ PAIN
- ☐ DEFORMITY (DESCRIBE)
- ☐ PARAPLEGIC
- ☐ SWELLING
- ☐ STIFFNESS
- ☐ HEMIPLEGIC

COMMENTS/SEVERITY/FREQUENCY:

PAIN: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED

TYPE:
- ☐ ACUTE
- ☐ AT REST
- ☐ CONSTANT
- ☐ CHRONIC
- ☐ SPORADIC
- ☐ WITH MOVEMENT

QUALITY:
- ☐ ACHING
- ☐ THROBBING
- ☐ BURNING
- ☐ DULL
- ☐ SHARP
- ☐ PRESSURE
- ☐ SHOOTING

COMMENTS/SEVERITY/FREQUENCY:

MENTAL STATUS: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ ALERT — MOOD:
- ☐ ORIENTED: — AFFECT:
- ☐ OTHER (SPECIFY):

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

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SECTION 6
NUTRITION

PRESENT HEIGHT: **CURRENT WEIGHT:** **USUAL WEIGHT:**

WEIGHT GAIN IN LAST 60 DAYS: ☐ YES ☐ NO
WEIGHT LOSS IN LAST 60 DAYS: ☐ YES ☐ NO
COMMENTS:

APPETITE:
☐ EXCELLENT
☐ GOOD
☐ FAIR
☐ POOR
CHANGES IN THE LAST 60 DAYS: ☐ YES ☐ NO
COMMENTS:

ACTIVITY LEVEL:
☐ VERY ACTIVE
☐ MODERATELY ACTIVE
☐ MILDLY ACTIVE
☐ MOSTLY SEDENTARY
COMMENTS:

FOOD ALLERGIES:
LIST:

FOOD DISLIKES:
LIST:

FOLLOWING SPECIAL DIET: ☐ YES ☐ NO
☐ MACROBIOTIC
☐ VEGETARIAN
☐ IMMUNE BOOSTING
☐ OTHER
COMMENTS:

SOCIAL/CULTURAL/RELIGIOUS FACTORS AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

PHYSIOLOGICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)

☐ CHEWING	☐ CONSTIPATION	☐ DRY MOUTH
☐ SWALLOWING	☐ DIARRHEA	☐ TASTE PERCEPTION
☐ NAUSEA	☐ ABDOMINAL CRAMPING/BLOATING	☐ APPETITE CHANGES
☐ VOMITING	☐ HEARTBURN/INDIGESTION	☐ OTHER (SPECIFY):

COMMENTS:

MEDICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)

☐ ULCER/STOMACH PROBLEMS	☐ MOUTH SORES/GUM INFECTIONS	☐ OTHER (SPECIFY):
☐ HEART DISEASE/HYPERTENSION	☐ FATIGUE	
☐ DIABETES	☐ FEVER	

COMMENTS:

PSYCHOSOCIAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

PHYSICAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

FINANCIAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

CLIENT NAME: **CHART NUMBER**:

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SECTION 6
NUTRITION (CONT'D)

NUTRITIONAL SUPPLEMENTS: (CHECK ALL THAT APPLY)

☐ VITAMINS ☐ HERBS/OTHER ☐ OTHER (SPECIFY):

☐ MINERALS ☐ ENSURE/BOOST

COMMENTS:

ALTERNATIVE NUTRITION:

☐ TPN ☐ LIPIDS ☐ TUBE FEEDING

COMMENTS:

OTHER BARRIERS TO ACHIEVING OPTIMAL NUTRITIONAL STATUS: ☐ YES ☐ NO

COMMENTS:

DOES CLIENT NEED ASSISTANCE WITH MEALS (MEALS ON WHEELS, ATTENDANT CARE, ETC.): ☐ YES ☐ NO

COMMENTS:

NUTRITIONAL EDUCATION PROVIDED: ☐ YES ☐ NO

COMMENTS:

NUTRITIONAL REFERRAL NEEDED: ☐ YES ☐ NO

COMMENTS:

NUTRITIONAL SUMMARY/PLAN:

SECTION 7
MEDICATION ADHERENCE

IS THE CLIENT ON MEDICATIONS (HAART OR OTHER): ☐ YES ☐ NO

IF YES, REFER TO MEDICATION SHEET

CLIENT UNDERSTANDS MEDICATION REGIMEN: ☐ YES ☐ NO

COMMENTS:

CLIENT ADHERES TO MEDICATION REGIMEN: ☐ YES ☐ NO

COMMENTS:

CLIENT'S ABILITY TO TAKE MEDICATIONS (HAART OR OTHER):

DID THE CLIENT MISS ANY DOSES YESTERDAY? ☐ YES ☐NO

DID THE CLIENT MISS ANY DOSES THE DAY BEFORE YESTERDAY? ☐ YES ☐NO

☐ CLIENT IS ABLE TO INDEPENDENTLY TAKE CORRECT MEDICATION(S) & DOSE AT CORRECT TIMES

☐ CLIENT IS ABLE TO TAKE CORRECT MEDICATION(S) & DOSES AT CORRECT TIMES WITH SUPERVISION OR ASSISTANCE

☐ CLIENT IS UNABLE TO TAKE MEDICATION(S) UNLESS ADMINISTERED BY SOMEONE ELSE

☐ UNABLE TO ASSESS CLIENT'S ABILITY TO TAKE MEDICATIONS

COMMENTS:

CLIENT NAME: **CHART NUMBER**:

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SECTION 7
MEDICATION ADHERENCE (CONT'D)

ADHERENCE BARRIERS:

☐ MEDICATION REGIMEN IS TOO COMPLEX
☐ SCHEDULING PROBLEMS
☐ MENTAL STATUS CHANGES
☐ ALCOHOL/DRUG USE/ABUSE
☐ DEPRESSION
☐ MEDICATION SIDE EFFECTS
☐ LANGUAGE/CULTURAL BARRIERS
☐ DIFFICULTY SWALLOWING MEDICATION
☐ MISUNDERSTANDING REGARDING MEDICATION EFFECTIVENESS
☐ NO SOCIAL SUPPORT
☐ NEEDS ASSISTANCE WITH ADL'S
☐ PROBLEMS OBTAINING MEDICATION OR REFILLS
☐ CULTURAL BELIEFS
☐ LACK OF REFRIGERATION, SAFE STORAGE
☐ CURRENT SUBSTANCE USE

COMMENTS:

IS THE CLIENT EXPERIENCING ANY OF THE FOLLOWING MEDICATION SIDE EFFECTS:

☐ ANOREXIA ☐ DIARRHEA ☐ DIZZINESS ☐ FATIGUE ☐ RASH
☐ NEUROPATHY ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ NAUSEA/VOMITING

HAS THE MEDICAL PROVIDER BEEN NOTIFIED: ☐ YES ☐ NO DATE: TIME:
COMMENTS:

COMPLIMENTARY ALTERNATIVE THERAPIES:

☐ ACUPUNCTURE
☐ ACUPRESSURE
☐ BIOFEEDBACK
☐ HERBAL
☐ HOMEOPATHY
☐ HYPNOSIS
☐ MASSAGE
☐ OTHER:

COMMENTS:

IV ACCESS/NAME AND LOCATION:

☐ PICC LOCATION:
☐ PORT-A-CATH LOCATION:
☐ GROSHONG LOCATION:
☐ HICKMAN LOCATION:

INFUSION COMPANY:
COMMENTS:

SECTION 8
RISK FACTORS FOR HIV TRANSMISSION

NEEDLE SHARING: ☐ YES ☐ NO
COMMENTS:

SEX WORK: ☐ YES ☐ NO
COMMENTS:

UNPROTECTED SEX WITH MEN: ☐ YES ☐ NO
COMMENTS:

UNPROTECTED SEX WITH WOMEN: ☐ YES ☐ NO
COMMENTS:

SEX WITH IDU: ☐ YES ☐ NO
COMMENTS:

SEX WITH HIV+ INDIVIDUAL: ☐ YES ☐ NO
COMMENTS:

DISCUSSION OF CURRENT HARM REDUCTION PRACTICES: ☐ YES ☐ NO
COMMENTS:

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
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Assessment

SECTION 9
RISK ASSESSMENT AND MITIGATION

DOES THE CLIENT HAVE ANY HISTORY OF INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION?

☐ YES ☐ NO

IF YES AND IF KNOWN, TYPE OF ABUSE:

☐ PHYSICAL ☐ FINANCIAL
☐ ISOLATION ☐ ABANDONMENT
☐ VERBAL ☐ SEXUAL
☐ NEGLECT BY SELF OR OTHER ☐ EMOTIONAL

IDENTIFYING INSTANCE(S):

REPORT MADE TO: ☐ APS ☐ CPS ☐ LAW ENFORCEMENT ☐ LONG TERM CARE OMBUDSMAN

OUTCOME:

COMMENTS:

SECTION 10
SUMMARY/CONCLUSIONS

SECTION 11
PLAN

SECTION 12
CERTIFICATION

MCWP ONLY: CLIENT MEETS THE MINIMUM NURSING FACILITY LEVEL OF CARE CRITERIA: ☐ YES ☐NO

CMP ONLY: CLIENT MEETS ELIGIBILITY REQUIREMENTS BASED ON THE FOLLOWING SYMPTOMS:

_____ _____

NURSE CASE MANAGER SIGNATURE/CREDENTIALS DATE

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/WAIVER CLIENT
MEDICATION SHEET

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

Start Date	Stop Date	Generic Name	Brand Name	Dose	Scheduled times
Nucleoside Analog Reverse Transcriptase Inhibitors (NRTI's)					
		Abacavir	Ziagen		
		Abacavir / Lamivudine (Ziagen + 3TC)	Epizcom		
		Zidovudine/Lamivudine/Abacavir (AZT + 3Tc + Abacovir)	Trizivir		
		Zidovudine/Lamivudine (AZT + 3TC)	Combivir		
		Didanosine (ddI)	Videx		
		Emtricitabine (FTC)	Emtriva		
		Lamivudine (3TC)	Epivir		
		Stavudine (d4T)	Zerit		
		Tenofovir	Viread		
		Tenofovir / Emtricitabine (Viread + Emtriva)	Truvada		
		Zalcitabine (ddC)	Hivid		
		Zidovudine (AZT or ZDV)	Retrovir		
Protease Inhibitors (PI's)					
		Amprenavir (APV)	Agenerase		
		Atazanavir	Reyataz		
		Fosamprenavir	Lexiva		
		Indinavir (IDV)	Crixivan		
		Lopinavir	Kaletra		
		Nelfinavir (NFV)	Viracept		
		Ritonavir (RTV)	Norvir		
		Saquinavir (SQV)	Fortovase		
Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI's)					
		Delavirdine	Rescriptor		
		Efavirenz	Sustiva		
		Nevirapine	Viramune		
HIV-1 Entry Inhibitors					
		Fuzeon (T-20)	Enfuvirtide		

Allergies to Medications:

NURSE CASE MANAGER SIGNATURE/CREDENTIALS	DATE:

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/WAIVER CLIENT
MEDICATION SHEET

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

ADDITIONAL SCHEDULED & PRN MEDICATIONS
(Include OTC & Herbal Remedies)

Start Date	Stop Date	Name of Drug	Dose Scheduled Times

NURSE CASE MANAGER SIGNATURE/CREDENTIALS	DATE:

CLIENT NAME: **CHART NUMBER**:

Cognitive and Functional Ability Scale For Persons With HIV Disease/AIDS

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

AREAS ASSESSED DATE:						
INITIALS:						
1. **NUTRITION** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
2. **HYGIENE** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
3. **EXCRETION** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
4. **ACTIVITY** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
5.**TREATMENT/MEDICATION** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
6. **TEACHING** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
7. **SUPPORT SYSTEMS** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
8. **MENTAL STATUS** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
9. **BEHAVIOR** INDEPENDENT 11 MINIMAL ASSISTANCE 7 MODERATE ASSISTANCE 5 CONSIDERABLE ASSIST 3 TOTALLY DEPENDENT 1						
TOTAL RATING						
NFLOC OR HIGHER? (MCWP ONLY)	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

NURSE CASE MANAGER SIGNATURE/CREDENTIALS	INITIALS:	DATE:
SOCIAL WORK CASE MANAGER SIGNATURE/CREDENTIALS	INITIALS:	DATE:

CLIENT NAME:	**CHART NUMBER:**

AIDS CMP/MCWP
Initial
Psychosocial
Assessment

SECTION 1
IDENTIFYING INFORMATION

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

HIV STATUS/DATE OF DIAGNOSIS:	**MODE OF TRANSMISSION**:
ADDRESS: STREET CITY ZIP CODE MAIL OK? ☐YES ☐ NO	**DATE OF ASSESSMENT**:
PHONE: IS IT OK TO LEAVE A MESSAGE? ☐ YES ☐ NO	**LOCATION OF ASSESSMENT**:
CLIENT SSN:	**GENDER**: ☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ FEMALE-TO-MALE ☐ MALE-TO-FEMALE
DOB:	**AGE**:
SEXUAL ORIENTATION: ☐ HOMOSEXUAL ☐ HETEROSEXUAL ☐ BISEXUAL ☐ UNKNOWN	**RELATIONSHIP STATUS**: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED ☐ DOMESTIC PARTNER ☐ SIGNIFICANT OTHER NAME:
PRIMARY LANGUAGE:	**RACE**: **ETHNICITY**: **CULTURAL ISSUES**:
RELIGIOUS/SPIRITUAL PREFERENCE:	**PRIMARY MEDICAL PROVIDER**: ADDRESS: PHONE:

EMERGENCY CONTACT:

PRIMARY:	**SECONDARY:**
NAME:	NAME:
RELATIONSHIP:	RELATIONSHIP:
PHONE:	PHONE:
AWARE OF STATUS: ☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO	OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO

WHAT OTHER AGENCIES ARE ASSISTING YOU?

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
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SECTION 2
LEGAL INFORMATION

ARRESTS: ☐ YES ☐ NO WHEN: WHERE: REASON:	**INCARCERATIONS:** ☐ YES ☐ NO WHEN: WHERE: REASON:
PAROLE: ☐ YES ☐ NO NAME: ADDRESS: PHONE: AWARE OF STATUS? ☐ YES ☐ NO	**PROBATION**: ☐ YES ☐ NO NAME: ADDRESS: PHONE: AWARE OF STATUS? ☐ YES ☐ NO
DPOA FOR HEALTHCARE COMPLETED: ☐ YES ☐ NO DECLINES: HEALTHCARE AGENT NAME: HEALTHCARE AGENT PHONE:	**DPOA FOR FINANCIAL COMPLETED:** ☐ YES ☐ NO DECLINES: FINANCIAL AGENT NAME: FINANCIAL AGENT PHONE:
WILL COMPLETED: ☐ YES ☐ NO COMMENTS:	**ATTORNEY:** ☐ YES ☐ NO NAME: ADDRESS: PHONE:
CONSERVATOR/GUARDIAN: ☐ YES ☐ NO NAME: ADDRESS: PHONE:	**REPRESENTATIVE PAYEE:** ☐ YES ☐ NO NAME: ADDRESS: PHONE:
CODE STATUS: DNR: ☐ YES ☐ NO FULL: ☐ YES ☐ NO COMMENTS:	**FUNERAL ARRANGEMENTS:** ☐ YES ☐ NO COMMENTS:
GUARDIAN OF MINOR CHILDREN: ☐ YES ☐ NO ☐ N/A NAME: ADDRESS: PHONE:	**PROTECTIVE SERVICES INVOLVED :** ADULT: ☐ YES ☐ NO CHILD: ☐ YES ☐ NO
DOES CLIENT NEED HELP WITH ANY LEGAL ISSUES? ☐ YES ☐ NO COMMENTS:	

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
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SECTION 3
RISK ASSESSMENT AND MITIGATION

DOES THE CLIENT HAVE ANY HISTORY OF INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION?

☐ YES ☐ NO

IF YES AND IF KNOWN, TYPE OF ABUSE:

☐ PHYSICAL ☐ FINANCIAL
☐ ISOLATION ☐ ABANDONMENT
☐ VERBAL ☐ SEXUAL
☐ NEGLECT BY SELF OR OTHER ☐ EMOTIONAL

IDENTIFYING INSTANCE(S):

REPORT MADE TO: ☐ APS ☐ CPS ☐ LAW ENFORCEMENT ☐ LONG TERM CARE OMBUDSMAN

OUTCOME:

COMMENTS:

SECTION 4
SOCIAL STATUS

PRIMARY CAREGIVER:

NAME:

RELATIONSHIP:

AWARE OF STATUS: ☐ YES ☐ NO

PHONE:

IS IT OK TO LEAVE A MESSAGE? ☐ YES ☐ NO

FAMILY OF ORIGIN:	**FAMILY HISTORY:**	**CHILDREN:** ☐ YES ☐ NO
MEMBERS: DYNAMICS:	PSYCHIATRIC HISTORY: KNOWLEDGE OF STATUS: COMMENTS:	STATUS: LOCATION: COMMENTS:

SUPPORT SYSTEM:

FRIENDS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
NEIGHBORS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
GROUPS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
ORGANIZATIONS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO

COMMENTS:

EDUCATION:	**DOES CLIENT HAVE PETS:** ☐ YES ☐ NO COMMENTS:
HOBBIES:	**LIVING ARRANGEMENTS/ENVIRONMENT:** NAME: RELATIONSHIP: AWARE OF STATUS: ☐ YES ☐ NO ENVIRONMENTAL ISSUES:

ADDITIONAL SUPPORT/REFERRAL NEEDED FOR CHILD CARE: ☐ YES ☐ NO

COMMENTS:

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
Initial
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Assessment

SECTION 5
MENTAL HEALTH/EMOTIONAL STATUS

MENTAL HEALTH HISTORY: INPATIENT: ☐ YES ☐ NO OUTPATIENT: ☐ YES ☐ NO MEDICATIONS: EVENTS: COMMENTS:	**CURRENT PSYCHIATRIC DIAGNOSIS:**
CURRENT PSYCHIATRIC MEDICATIONS:	**ADJUSTMENT TO ILLNESS:**
COPING STRATEGIES:	**STRENGTHS:** **WEAKNESSES:**
CURRENT THERAPIST: AWARE OF STATUS: ☐ YES ☐ NO	**CURRENT SUPPORT GROUP:** AWARE OF STATUS: ☐ YES ☐ NO
CURRENT PSYCHIATRIST: AWARE OF STATUS: ☐ YES ☐ NO	**DEPRESSION:** ☐ YES ☐ NO COMMENTS:
ANXIETY: ☐ YES ☐ NO COMMENTS:	**AIDS RELATED DEMENTIA:** ☐ YES ☐ NO COMMENTS:
DOES CLIENT NEED MENTAL HEALTH REFERRALS: ☐ YES ☐ NO COMMENTS:	

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
Initial
Psychosocial
Assessment

SECTION 6
MENTAL STATUS EXAMINATION (MSE)

APPEARANCE:

GROOMING: ☐ NEAT/CLEAN ☐ DISHEVELED/DIRTY
HYGIENE: ☐ CLEAN ☐ MALODOROUS
AGE: ☐ LOOKS OLDER THAN AGE ☐ LOOKS YOUNGER THAN AGE
OTHER:

EYE CONTACT:

☐ APPROPRIATE
☐ MINIMAL ERRATIC
☐ NONE

BEHAVIOR/MOTOR ACTIVITY:

☐ RELAXED
☐ RESTLESS
☐ PACING
☐ SEDATE
☐ THREATENING
☐ CATATONIC
☐ POSTURING
☐ TREMORS/TICS
☐ APPROPRIATE TO SITUATION
☐ INAPPROPRIATE TO SITUATION
☐ OTHER:

ATTITUDE:

☐ CALM
☐ PLEASANT
☐ COOPERATIVE
☐ RESISTANT
☐ DEFENSIVE
☐ EVASIVE
☐ GUARDED
☐ SUSPICIOUS
☐ DEMANDING
☐ MANIPULATIVE
☐ WITHDRAWN
☐ HOSTILE
☐ OTHER

SPEECH:

☐ SLOW
☐ RAPID
☐ CLEAR
☐ MUMBLED
☐ SLURRED
☐ SOFT
☐ LOUD
☐ INCREASED QUANTITY
☐ DECREASED QUANTITY
☐ OTHER:

MOOD:

☐ NORMAL
☐ EUPHORIC
☐ ELEVATED
☐ DEPRESSED
☐ ANGRY
☐ IRRITABLE
☐ AGITATED
☐ ANXIOUS
☐ APATHETIC
☐ PLEASANT
☐ UNPLEASANT
☐ NEUTRAL
☐ FEARFUL
☐ ELATED
☐ SAD
☐ OTHER:

AFFECT:

☐ BROAD
☐ RESTRICTED
☐ BLUNTED
☐ FLAT
☐ LABILE
☐ APPROPRIATE TO SITUATION
☐ INAPPROPRIATE TO SITUATION
☐ OTHER:

ORIENTATION:

☐ PERSON
☐ PLACE
☐ TIME
☐ SITUATION

ATTENTION:

☐ NORMAL
☐ HYPER
☐ VIGILANT
☐ DISTRACTIBLE

CONCENTRATION:

☐ GOOD
☐ FAIR
☐ POOR

MEMORY:

IMMEDIATE: ☐ GOOD ☐ FAIR ☐ POOR
RECENT: ☐ GOOD ☐ FAIR ☐ POOR
REMOTE: ☐ GOOD ☐ FAIR ☐ POOR

COMMENTS:

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
Initial
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Assessment

SECTION 6
MENTAL STATUS EXAMINATION (MSE) (CONT'D)

THOUGHT CONTENT:

☐ IDEAS OF REFERENCE	☐ DELUSIONS	☐ HYPOCHONDRIACHAL
☐ GRANDIOSITY	☐ DEPERSONALIZATION	☐ RELIGIOUSLY PREOCCUPIED
☐ PHOBIAS	☐ SUICIDAL IDEATIONS	☐ SEXUALLY PREOCCUPIED
☐ OBSESSIONS/COMPULSIONS	☐ HOMICIDAL IDEATIONS	☐ OTHER:

THOUGHT PROCESS:

☐ NORMAL	☐ TANGENTIAL	☐ LOOSE ASSOCIATIONS
☐ SLOW/INHIBITED	☐ BLOCKING	☐ OTHER:
☐ RAPID/RACING	☐ FLIGHT OF IDEAS	
☐ CIRCUMSTANTIAL	☐ PARANOID	

PERCEPTION:

☐ HALLUCINATIONS:

☐ AUDITORY	☐ GUSTATORY
☐ VISUAL	☐ TACTILE
☐ OLFACTORY	☐ SOMATIC

JUDGEMENT:

☐ GOOD
☐ FAIR
☐ POOR

INSIGHT:

☐ GOOD
☐ FAIR
☐ POOR

IMPULSE CONTROL:

☐ GOOD
☐ FAIR
☐ POOR

CLIENT NAME: **CHART NUMBER**:

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SECTION 7
SUBSTANCE USE/ABUSE INFORMATION

PAST: ☐ YES ☐ NO **DRUG(S) OF CHOICE:** **CURRENT:** ☐ YES ☐ NO **SOCIAL:** ☐ YES ☐ NO	**TREATMENT HISTORY:** INPATIENT: ☐ YES ☐ NO DATES: OUTPATIENT: ☐ YES ☐ NO DATES:
ALCOHOL: ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:	**CANNABIS:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:
HEROIN: ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:	**CRACK/COCAINE:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:
CRANK/METH/SPEED: ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:	**PRESCRIPTIONS:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:
CAFFEINE: ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:	**NICOTINE:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:
INHALANTS: ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:	**GHB/ECSTACY/KETAMINE:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:
HALLUCINOGENS: ☐ YES ☐ NO (LSD, MESCALINE, PCP) FIRST USE: LAST USE: COMMENTS:	**OTHER:** ☐ YES ☐ NO FIRST USE: LAST USE: COMMENTS:

IN NEED OF DETOX OR TREATMENT PROGRAM: ☐ YES ☐ NO COMMENTS:

REFERRAL TO AA, OUTPATIENT: ☐ YES ☐ NO COMMENTS:

SECTION 8
RISK FACTORS FOR HIV TRANSMISSION

NEEDLE SHARING: ☐ YES ☐ NO COMMENTS:	**SEX WORK:** ☐ YES ☐ NO COMMENTS:
UNPROTECTED SEX WITH MEN: ☐ YES ☐ NO COMMENTS:	**UNPROTECTED SEX WITH WOMEN:** ☐ YES ☐ NO COMMENTS:
SEX WITH IDU: ☐ YES ☐ NO COMMENTS:	**SEX WITH HIV+ INDIVIDUAL:** ☐ YES ☐ NO COMMENTS:

DISCUSSION OF CURRENT HARM REDUCTION PRACTICES: ☐ YES ☐ NO
COMMENTS:

CLIENT NAME:	**CHART NUMBER**:

AIDS CMP/MCWP
Initial
Psychosocial
Assessment

SECTION 9
FOOD/HOUSING/TRANSPORTATION

CLIENT CURRENTLY RECEIVES:

FOOD:
- ☐ FOOD BANK
- ☐ FOOD VOUCHERS
- ☐ MEALS ON WHEELS
- ☐ OTHER

HOUSING:
- ☐ HOPWA
- ☐ SECTION 8
- ☐ OTHER

TRANSPORTATION:
- ☐ BUS
- ☐ TAXI
- ☐ OTHER

DOES CLIENT NEED TRANSPORTATION, FOOD, HOUSING ASSISTANCE: ☐ YES ☐ NO
COMMENTS:

SECTION 10
PRACTICAL SUPPORT

ACTIVITIES OF DAILY LIVING:

	HOW ARE NEEDS MET/BY WHOM:	ASSISTANCE REQUIRED:
MEALS		SEE SECTION 8
TRANSPORTATION		SEE SECTION 8
PERSONAL CARE		☐ YES ☐ NO
HOUSEKEEPING		☐ YES ☐ NO
MOBILITY		☐ YES ☐ NO
MEDICATIONS		☐ YES ☐ NO
LAUNDRY		☐ YES ☐ NO
SHOPPING		☐ YES ☐ NO
APPOINTMENTS		☐ YES ☐ NO

ATTENDANT CARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

IHSS: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

HOSPICE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

LIFELINE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

CHILDCARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

ADULT DAY CARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

MEDICATION MANAGEMENT: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

OTHER: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

CLIENT NAME: **CHART NUMBER:**

AIDS CMP/MCWP
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SECTION 11
FINANCIAL ASSESSMENT

EMPLOYMENT/OCCUPATION HISTORY:
COMMENTS:

CURRENT EMPLOYMENT/OCCUPATION STATUS:
AWARE OF STATUS: ☐ YES ☐ NO
MAY WE LEAVE MESSAGE: ☐ YES ☐ NO
COMMENTS:

INCOME SOURCE:

☐ SSI	$	☐ TANF	$	☐ WIC	$
☐ SSDI	$	☐ UNEMPLOYMENT	$	☐ SECTION 8	$
☐ GA	$	☐ FOOD STAMPS	$	☐ OTHER	$

MONTHLY EXPENSES:

HOUSING (RENT/MORTGAGE):	$	CABLE	$
UTILITIES (GAS & ELECTRIC):	$	CLOTHING:	$
TELEPHONE:	$	ENTERTAINMENT:	$
FOOD:	$	TOBACCO:	$
TRANSPORTATION:	$	ALCOHOL:	$
MEDICAL:	$	MISCELLANEOUS/OTHER:	$
AUTO (LOAN & INSURANCE):	$		

NET INCOME: INCOME $ - EXPENSES $ = NET INCOME $
COMMENTS:

DOES CLIENT NEED FINANCIAL COUNSELING OR ASSISTANCE WITH BENEFITS: ☐ YES ☐ NO

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
Initial
Psychosocial
Assessment

SECTION 12
SUMMARY/CONCLUSIONS

SECTION 13
PLAN

SECTION 14
SIGNATURE

_____	_____	_____
SOCIAL WORK CASE MANAGER	CREDENTIALS	DATE

CLIENT NAME: **CHART NUMBER**:

AIDS CMP/MCWP
Resource Evaluation Assessment/Reassessment

SECTION 1
PRIVATE MEDICAL INSURANCE

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

INSURANCE COMPANY:	**POLICY/GROUP NUMBER:**
ADDRESS: CITY/STATE: ZIP CODE:	CONTACT PERSON: PHONE NUMBER:

IS CLIENT ELIGIBLE FOR CARE/HIPP: ☐ YES ☐ NO
IF YES, IS CLIENT ENROLLED: ☐ YES ☐ NO
IF NO, REFERRED: ☐ YES ☐ NO

ELIGIBILITY:

	PROVIDED:	AVAILABLE:		PROVIDED:	AVAILABLE:
DME:	☐ YES ☐ NO	☐ YES ☐ NO	HOSPICE:	☐ YES ☐ NO	☐ YES ☐ NO
PSYCHOTHERAPY:	☐ YES ☐ NO	☐ YES ☐ NO	SKILLED NURSING:	☐ YES ☐ NO	☐ YES ☐ NO
NUTRITIONAL COUNSELING:	☐ YES ☐ NO	☐ YES ☐ NO	CNA/CHHA:	☐ YES ☐ NO	☐ YES ☐ NO
NUTRITIONAL SUPPLEMENTS:	☐ YES ☐ NO	☐ YES ☐ NO	HOMEMAKER:	☐ YES ☐ NO	☐ YES ☐ NO
MEDICAL TRANSPORTATION:	☐ YES ☐ NO	☐ YES ☐ NO			

LIMITATIONS/EXCLUSIONS/PRIOR AUTHORIZATIONS:

CHANGES: ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:

SECTION 2
MEDICARE

MEDICARE: ☐ YES ☐ NO IF NO, REFERRED: ☐ YES ☐ NO	**MEDICARE NUMBER:** EFFECTIVE DATE: PART A: ☐ YES ☐ NO PART B: ☐ YES ☐ NO PART D: ☐ YES ☐ NO

CHANGES: ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:

SECTION 3
MEDI-CAL MANAGED CARE

NAME OF PLAN:	**POLICY/GROUP NUMBER:**
CONTACT PERSON: PHONE:	**PHYSICIAN NAME:** PHONE:

CHANGES: ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:

SECTION 4
MEDI-CAL

MEDI-CAL: ☐ YES ☐ NO IF NO, REFERRED: ☐ YES ☐ NO	**MEDI-CAL NUMBER:** ISSUE DATE:
ELIGIBILITY WORKER: PHONE NUMBER:	**SOC $:** MEETS MONTHLY SOC THROUGH: ☐ ADAP ☐ IHSS ☐ OTHER:

CHANGES: ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:	**CHANGES:** ☐ YES ☐ NO DATE: COMMENTS:

CLIENT NAME:	**CHART NUMBER:**

AIDS CMP/MCWP
Resource Evaluation Assessment/Reassessment

SECTION 5
AIDS DRUG ASSISTANCE PROGRAM (ADAP)

ADAP: ☐ YES ☐ NO IF NO, REFERRED: ☐ YES ☐ NO	**DOES CLIENT UTILIZE ADAP FOR HIV DRUGS :** ☐ YES ☐ NO

PHARMACY:	**PHARMACY PHONE:**	**PHARMACY CONTACT:**

CHANGES: ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:
COMMENTS:	COMMENTS:	COMMENTS:	COMMENTS:

SECTION 6
CALIFORNIA CHILDREN'S SERVICES (CCS)
(Children Only)

HAS CHILD APPLIED FOR CCS: ☐ YES ☐ NO IF NO, REFERRED: ☐ YES ☐ NO	**ENROLLMENT DATE:**
CASE WORKER:	**CASE WORKER PHONE NUMBER:**

CHANGES: ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:
COMMENTS:	COMMENTS:	COMMENTS:	COMMENTS:

SECTION 7
IN HOME SUPPORT SERVICES (IHSS)

IS CLIENT ENROLLED: ☐ YES ☐ NO
IF YES, HOURS AUTHORIZED/MONTH:
IF NO, REFERRED: ☐ YES ☐ NO

CASE WORKER: PHONE NUMBER:	**IHSS WORKER:** PHONE NUMBER:
DATE OF REFERRAL FOR REEVALUATION OF IHSS HOURS: DATE: DATE: DATE: DATE: DATE:	HOURS CHANGED: ☐ YES ☐ NO (SEE SERVICE PLAN) HOURS CHANGED: ☐ YES ☐ NO (SEE SERVICE PLAN) HOURS CHANGED: ☐ YES ☐ NO (SEE SERVICE PLAN) HOURS CHANGED: ☐ YES ☐ NO (SEE SERVICE PLAN) HOURS CHANGED: ☐ YES ☐ NO (SEE SERVICE PLAN)

CHANGES: ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:	**CHANGES:** ☐ YES ☐ NO DATE:
COMMENTS:	COMMENTS:	COMMENTS:	COMMENTS:

SECTION 8
SIGNATURE

CASE MANAGER: _____ TITLE: _____ DATE: _____

CASE MANAGER: _____ TITLE: _____ DATE: _____

CASE MANAGER: _____ TITLE: _____ DATE: _____

CASE MANAGER: _____ TITLE: _____ DATE: _____

CLIENT NAME:	**CHART NUMBER:**

AIDS CMP/MCWP
Home Environment
Assessment/Reassessment

SECTION 1
IDENTIFYING INFORMATION

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

CLIENT ADDRESS: **PHONE:**
ADDRESS:
CITY/STATE: ZIP CODE:

LENGTH ON TIME AT THIS ADDRESS:

SECTION 2
ASSESSMENT INFORMATION

TYPE:
☐ INITIAL: REQUIRED IN THE HOME WHEN THE CLIENT IS ENROLLED
☐ REASSESSMENT: REQUIRED IN THE HOME AT LEAST ANNUALLY
☐ CLIENT MOVED

DATE OF ASSESSMENT:

SECTION 3
RESIDENCE TYPE

☐ HOMELESS (DOCUMENTATION OF ASSISTANCE WITH HOUSING PLAN MUST BE PRESENT)
☐ CLIENT OWNED/RENTED RESIDENCE
☐ BOARD AND CARE
☐ ASSISTED LIVING
☐ RCFCI
☐ RCFE
☐ ARF
☐ RENTED ROOM
☐ FAMILY MEMBER RESIDENCE
☐ OTHER:

SECTION 4
RESIDENCE CONDITION

	ADEQUATE	INADEQUATE	N/A
NEIGHBORHOOD SAFETY: (INCLUDING APARTMENT COMPLEX GROUNDS, ETC.)	☐	☐	☐
RESIDENCE ACCESS:			
• STAIRS ACCESSING RESIDENCE/BUILDING AND WITHIN RESIDENCE/BUILDING	☐	☐	☐
• ENTRANCES/EXITS AND WINDOWS WORK PROPERLY, ARE PROPERLY SECURED, AND ARE UNOBSTRUCTED (INCLUDING ELEVATORS)	☐	☐	☐
RESIDENCE FEATURES:			
• SPACE (ALSO CONSIDER IF ADEQUATE FOR MEDICAL EQUIPMENT)	☐	☐	☐
• FUNCTIONAL PLUMBING (RUNNING WATER) AND SUPPLY OF POTABLE WATER	☐	☐	☐
• TUB/SHOWER AND HOT WATER THROUGHOUT	☐	☐	☐
• CONVENIENT, FUNCTIONING TOILET FACILITIES	☐	☐	☐
• HEATING/COOLING/VENTILATION SYSTEMS ARE FUNCTIONAL AND SAFE	☐	☐	☐
• COOKING FACILITIES AND REFRIGERATION	☐	☐	☐
• LAUNDRY FACILITIES	☐	☐	☐
• TELEPHONE (FUNCTIONING AND ADEQUATE SERVICE	☐	☐	☐
• LIGHTING IS ENOUGH TO BE SAFE	☐	☐	☐
• SMOKE AND FIRE DETECTORS ROOFING AND/OR CEILING CONDITION (DOES NOT LEAK)	☐	☐	☐
• OTHER:	☐	☐	☐
• OTHER:	☐	☐	☐

CLIENT NAME: **CHART NUMBER:**

AIDS CMP/MCWP
Home Environment
Assessment/Reassessment

SECTION 5
PETS

NUMBER OF PETS: **TYPES:**	ADEQUATE	INADEQUATE	N/A
PET(S) ARE CLEAN AND APPEAR HEALTHY AND SPACE IS CLEAN	☐	☐	☐

SECTION 6
GENERAL ASSESSMENTS

GENERAL CONDITION OF LIVING AREA: (CLUTTER, LOOSE RUGS, WORN ELECTRICAL CORDS, WALKUP, STATE OF REPAIR, SANITATION AND SAFETY)

GENERAL COMMENTS/NEED FOR HOME MODIFICATIONS/ADAPTIVE DEVICES:

IF ELEMENT IDENTIFIED AS INADEQUATE, INTERVENTION PROVIDED (NOTE: ADDRESS IF INADEQUATE SITUATION WARRANTS OR RESULTS IN REPORTING AN INSTANCE OF ABUSE, NEGLECT, OR EXPLOITATION. IF SO, PROVIDE APPROPRIATE DOCUMENTATION IN REASSESSMENT):

SECTION 7
SIGNATURE

_____	_____	_____
CASE MANAGER	CREDENTIALS	DATE

CLIENT NAME:	**CHART NUMBER:**

Form	Number	Revision Date	Type
Nursing Reassessment	CMP/MCWP 10*	3/06	Sample
Psychosocial Reassessment	CMP/MCWP 11*	3/06	Sample
Cost Avoidance	CMP/MCWP 12*	3/06	Sample
Interdisciplinary Team Case Conference	CMP/MCWP 13*	3/06	Sample

Mandatory Forms: must be used "as is"; no changes may be made to these forms.
Sample Forms: may be revised to meet an individual contractor's needs but must contain all of the elements within the forms. Forms can be identified as either sample or mandatory by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (S) for sample forms or (M) for mandatory forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

***** These are fill-and-print forms.

COST AVOIDANCE INSTRUCTIONS

Cost avoidance is the process used to ensure that all available resources are screened for and accessed prior to utilization of Case Management Program (CMP) and Medi-Cal Waiver Program (MCWP) funds when arranging client services.

Clients With Private Health Insurance (e.g. Kaiser, Healthnet, Blue Cross, etc.)

A. For the MCWP there is also a federal third party liability/cost avoidance requirement that applies to clients with private insurance. Certain procedures must be in place for both the CMP and the MCWP to assure that all other sources of funding are exhausted before using program funds. This includes:

- Screening clients for other health coverage and/or private insurance payment sources for services;
- Seeking reimbursement from all other funding sources prior to billing CMP or MCWP;
- Accessing all other potential resources for services prior to using CMP/MCWP funds (see *B* in this section below);
- Advocating on behalf of the client to access other resources and services; and
- Maintaining appropriate documentation in the client record.

Contractor procedures must address all items and be in the same order as the following list:

1. As part of the eligibility/intake process, a full resource evaluation is completed to obtain information concerning the client's healthcare coverage. This information is documented in the case record.

2. The Nurse Case Manager (NCM)/Social Work Case Manager (SWCM) contacts known payers of health care for the client to verify eligibility for coverage and to determine third party responsibility for payment of services to the client.

3. If it is determined that the client has health insurance coverage other than Medicare and/or Medi-Cal, the NCM/SWCM verifies the benefits available under the client's health plan, including services covered under Medi-Cal, CMP, and MCWP. The NCM/SWCM verifies and documents coverage limitations and exclusions, and negotiates with the insurance company case worker to assure maximum coverage is made. In cases where the insurance company is reluctant to cover services that appear to be eligible for coverage, the NCM/SWCM advocates on behalf of the client to access these services.

4. For services covered by the insurer, the NCM/SWCM finds out from the insurance company case worker which service providers are authorized to provide the requested services and facilitates referral to the appropriate service provider. The service provider arranges for payment from the insurance company for covered services.

5. Subcontractors are required to bill all other payer sources prior to billing the CMP or MCWP. This includes Medicare, Medi-Cal, and/or private insurance. Services cannot be billed to the CMP or MCWP until all other payer sources have been exhausted.

6. If the client has Medicare and/or Medi-Cal, the CMP or MCWP contractor or subcontractor bills:
   a. Medicare for all Medicare-covered services.
   b. Medi-Cal for all Medi-Cal only covered services, utilizing the Treatment Authorization Request (TAR) process if necessary.
   c. CMP for all CMP only covered services and services denied by primary payers.
   d. Medi-Cal for all MCWP only covered services and services denied by primary payers.

7. When there is a third party payer, the NCM/SWCM provides the following billing information to the service provider:
   a. Primary Payer, case worker name, address, and telephone number.
   b. Client Group and policy number.
   c. Coverage requirements and limitations.
   d. Prior Authorization requirements, if any.

8. If there is a change in the service delivery pattern (e.g., increase in attendant care from four hours, three days/week to eight hours, seven days/week), the new orders will be documented and provided to the service provider. Contact will be made with the insurance company case worker to attempt to negotiate further coverage, as applicable.

9. The NCM/SWCM documents the lack or limitations of coverage in the case record. The subcontractor is instructed to forward a copy of the Explanation of Benefits, or other such documentation, with any bill submitted to the MCWP if the client has other health coverage. (Documentation may be kept in the client chart, fiscal office, or other designated area.)

10. The MCWP project monitors the subcontractor's invoices to verify that services billed have prior authorization from the NCM and verifies that payment has been denied by other health coverage, when applicable.

11. Cost avoidance activities must be documented in a standardized format in the client record, following the contractor's policy and procedures whenever program funds are used to pay for services to clients (excluding case management). This documentation must include:

    a. A full resource evaluation including a list of all known payers of health care, and group and member number. (This should be included on the resource evaluation form);

    b. For payers other than Medicare or Medi-Cal, the name and telephone number of the contact person/representative. (This may be included with the above information);

    c. A record of contact made with the representative noted in item 4 above. (This should not be in progress notes. A separate log for documenting cost these contacts should be developed.);

    d. For clients with private insurance policies, coverage limitations, and exclusions, any negotiation regarding coverage, and prior authorization requested. (This may be included with the record of contact);

    e. Contact with service provider(s) regarding requirement to bill to private insurance or Medicare, and submit a TAR to Medi-Cal. (This may be included with the record of contact);

    f. Written authorization by the case manager to use CMP/MCWP funds if no other funding source is available (e.g., private health insurance, Medi-Cal, Ryan White Care Act funds, County funds, etc.); and

    g. If billing CMP or MCWP, a copy of the request for service provider(s) to forward a copy of the denial of service must be maintained in the client record or program file. (This may be included with the record of contact).

B. Cost avoidance also refers to accessing all other potential resources for services prior to using CMP or MCWP funds for services such as food vouchers, gas vouchers, taxi vouchers, bus passes, housing, utilities, etc. The NCM, SWCM, or other CMP/MCWP staff (e.g. Case Aide, Benefits Counselor) must document these instances of cost avoidance in the client chart each time they occur. Documentation should cover what agencies/resources were accessed, what services were requested, and why services could not be provided. This can be done either in progress notes or on a form designated for this purpose.

Clients Without Private Health Insurance (e.g. Medi-Cal, Medi-Cal Managed Care, Medicare, etc.)

All other potential resources must be accessed prior to using CMP or MCWP funds, including attendant care, homemaker services, skilled nursing, food vouchers, gas vouchers, taxi vouchers, bus passes, housing, utilities, etc. The NCM, SWCM, or other CMP/MCWP staff (e.g. Case Aide, Benefits Counselor) must document these instances of cost avoidance in the client chart each time they occur. Documentation should include what agencies were accessed, what services were requested, and why services could not be provided. This can be done either in progress notes or on a form designated for this purpose.

Please see the sample form in this section, Cost Avoidance (CMP/MCWP 12), for use in documenting cost avoidance activities.

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SECTION 1
IDENTIFYING INFORMATION

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

HIV STATUS/DATE OF DIAGNOSIS:

MODE OF TRANSMISSION:

ADDRESS: (IF CHANGED IN PAST 60 DAYS)
STREET
CITY ZIP CODE

MAIL OK? ☐YES ☐ NO

DATE OF REASSESSMENT:

PHONE:
IS IT OK TO LEAVE A MESSAGE? ☐ YES ☐ NO

LOCATION OF REASSESSMENT:

RELATIONSHIP STATUS (IF CHANGED IN PAST 60 DAYS):
☐ MARRIED
☐ SINGLE
☐ DIVORCED
☐ WIDOWED
☐ SEPARATED
☐ DOMESTIC PARTNER
☐ SIGNIFICANT OTHER
NAME:

EMERGENCY CONTACT (IF CHANGED IN PAST 60 DAYS):

PRIMARY:
NAME:
RELATIONSHIP:
PHONE:
AWARE OF STATUS: ☐ YES ☐ NO
OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO

SECONDARY:
NAME:
RELATIONSHIP:
PHONE:
AWARE OF STATUS: ☐ YES ☐ NO
OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO

WHAT OTHER AGENCIES ARE ASSISTING YOU?

SECTION 2
CURRENT HEALTH STATUS

HIV DISEASE STATUS:
MOST RECENT CD4 COUNT:
MOST RECENT VIRAL LOAD:

CURRENT TUBERCULOSIS STATUS:
LATEST TST RESULTS: DATE:
LATEST CXR RESULTS: DATE:
PROPHYLACTIC TREATMENT: ☐ YES ☐ NO

ALLERGIES (IF CHANGES IN PAST 60 DAYS):
☐ NO KNOWN ALLERGIES
☐ MEDICATION
☐ FOOD
☐ ENVIRONMENT
COMMENTS:

RECENT HIV RELATED EMERGENCY ROOM VISITS/HOSPITALIZATIONS: ☐ YES ☐ NO
REASON:
LOCATIONS:
COMMENTS:

DATE:
LENGTH OF STAY:

CLIENT NAME:

CHART NUMBER:

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SECTION 3
SEXUAL ACTIVITY IN PAST 60 DAYS

FEMALE:

SEXUALLY ACTIVE: ☐ YES ☐ NO

USES SAFE SEX PRACTICES: ☐ YES ☐ NO
(REQUIRES DISCUSSION WITH CLIENT)

BIRTH CONTROL: ☐ YES ☐ NO
METHOD:

LAST MENSTRUAL PERIOD: DATE:

CURRENTLY PREGNANT: ☐ YES ☐ NO
PLANS TO CONTINUE PREGNANCY ☐ YES ☐ NO
PLANS TO TERMINATE PREGNANCY ☐ YES ☐ NO
UNDECIDED ☐ YES ☐ NO

UNDERSTANDS TREATMENT OPTIONS FOR VERTICAL TRANSMISSION RISK REDUCTION ☐ YES ☐ NO

DATE OF LAST PAP:
RESULTS OF LAST PAP: ☐ NORMAL ☐ ABNORMAL

PERFORMS SBE MONTHLY: ☐ YES ☐ NO

DATE OF LAST MAMMOGRAM:
RESULTS OF MAMMOGRAM: ☐ NORMAL ☐ ABNORMAL

VAGINAL BURNING, ITCHING, DISCHARGE ☐ YES ☐ NO
COMMENTS:

MALE:

SEXUALLY ACTIVE: ☐ YES ☐ NO

USES SAFE SEX PRACTICES: ☐ YES ☐ NO
(REQUIRES DISCUSSION WITH CLIENT)

PROSTATE DISORDER: ☐ YES ☐ NO

LAST RECTAL/PROSTATE EXAM:
RESULTS OF RECTAL/PROSTATE EXAM: ☐ NORMAL ☐ ABNORMAL

LAST PSA TEST:
RESULTS OF PSA TEST: ☐ NORMAL ☐ ABNORMAL

PERFORMS SELF TESTICULAR EXAM MONTHLY: ☐ YES ☐ NO
COMMENTS:

SECTION 4
SERVICE PROVIDERS

PRIMARY MEDICAL PROVIDER: CHANGES: ☐ YES ☐ NO
IF YES, COMPLETE INFORMATION BELOW:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

PHARMACY: CHANGES: ☐ YES ☐ NO
IF YES, COMPLETE INFORMATION BELOW:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

DENTIST: CHANGES: ☐ YES ☐ NO
IF YES, COMPLETE INFORMATION BELOW:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

OTHER PROVIDERS: CHANGES: ☐ YES ☐ NO
IF YES, COMPLETE INFORMATION BELOW:
NAME:
STREET ADDRESS:
CITY AND ZIP CODE
PHONE NUMBER:

CLIENT NAME: **CHART NUMBER**:

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SECTION 5
SYSTEMS REVIEW OF PAST 60 DAYS

GENERAL APPEARANCE:

CHIEF COMPLAINT:

CLIENT'S PERCEPTION OF ILLNESS:

VITAL SIGNS AS INDICATED:
TEMPERATURE:
BLOOD PRESSURE:
PULSE:
RESPIRATIONS:

HEAD AND NECK: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ HEADACHES
☐ MASSES/NODES
COMMENTS/SEVERITY/FREQUENCY:

EYES: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ VISUAL CHANGE
☐ FLOATERS
☐ ITCHING/DISCHARGE
☐ REDNESS
☐ GLASSES/CONTACTS
☐ BLIND R/L
☐ BLURRED VISION
☐ LIGHT FLASHES
☐ GLAUCOMA
☐ PERRLA
COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

SECTION 5
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)

EARS/NOSE: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ TINNITUS
- ☐ DEAF R/L
- ☐ HARD OF HEARING R/L
- ☐ DRAINAGE
- ☐ REDNESS

COMMENTS/SEVERITY/FREQUENCY:

MOUTH/THROAT: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ BLEEDING GUMS
- ☐ ORAL LESIONS
- ☐ CANDIDIASIS
- ☐ DIFFICULTY SWALLOWING
- ☐ WHITE PLAQUES
- ☐ VESICLE
- ☐ HOARSENESS

COMMENTS/SEVERITY/FREQUENCY:

CARDIAC/CIRCULATORY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ RATE/RHYTHM
- ☐ ORTHOPNEA
- ☐ DYSPNEA ON EXERTION
- ☐ PAROXYSMAL NOCTURNAL DYSPNEA
- ☐ CHEST PAIN (DESCRIBE)
- ☐ EDEMA
- ☐ PERIPHERAL PULSES
- ☐ ASCITES
- ☐ LIPID PANELS

COMMENTS/SEVERITY/FREQUENCY:

SKIN: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ WARM
- ☐ DRY
- ☐ MOIST
- ☐ COLOR
- ☐ POOR TURGOR
- ☐ LESIONS (LOCATION, SIZE, DRAINAGE)
- ☐ KS LESIONS
- ☐ VESICLES
- ☐ BRUISING
- ☐ ITCHING
- ☐ RASH
- ☐ NUMBNESS
- ☐ TINGLING
- ☐ PETECHIAE

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

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SECTION 5
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)

RESPIRATORY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ RATE/RHYTHM
- ☐ APNEA
- ☐ DYSPNEA AT REST
- ☐ TACHYPNEA
- ☐ BREATH SOUNDS (DESCRIBE)
- ☐ NON-PRODUCTIVE COUGH
- ☐ PRODUCTIVE COUGH
- ☐ SOB AT REST
- ☐ DYSPNEA ON EXERTION
- ☐ OXYGEN
- ☐ CYANOSIS

COMMENTS/SEVERITY/FREQUENCY:

GASTROINTESTINAL: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ ABDOMINAL DISTENTION
- ☐ CONSTIPATION
- ☐ CRAMPING
- ☐ BLOODY STOOLS
- ☐ FLATULENCE
- ☐ DIARRHEA
- ☐ NAUSEA/VOMITING
- ☐ HEARTBURN
- ☐ INCONTINENCE

COMMENTS/SEVERITY/FREQUENCY:

GENITOURINARY: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ FREQUENCY
- ☐ URGENCY
- ☐ DYSURIA
- ☐ HEMATURIA
- ☐ LESION
- ☐ BURNING
- ☐ INCONTINENCE
- ☐ INFLAMMATION
- ☐ DISCHARGE/DRAINAGE

FEMALE:
- ☐ CANDIDIASIS
- ☐ VAGINAL DISCHARGE
- ☐ DYSMENORRHEA
- ☐ ABNORMAL BLEEDING

COMMENTS/SEVERITY/FREQUENCY:

ENDOCRINE: (CHECK ALL THAT APPLY)
- ☐ NO PROBLEMS IDENTIFIED
- ☐ FATIGUE
- ☐ IRRITABILITY
- ☐ MENTAL STATUS CHANGES
- ☐ WEIGHT CHANGE
- ☐ OBESITY
- ☐ BLOOD SUGAR LEVELS

COMMENTS/SEVERITY/FREQUENCY:

CLIENT NAME: **CHART NUMBER**:

SECTION 5
SYSTEMS REVIEW OF PAST 60 DAYS (CONT'D)

CENTRAL NERVOUS SYSTEM: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ SEIZURES
☐ BEHAVIORAL CHANGES
☐ DELUSIONS
☐ APHASIA
☐ FINE MOTOR CHANGES
☐ TREMORS
☐ SYNCOPE
☐ MEMORY LOSS
☐ IMPAIRED DECISION MAKING
☐ HALLUCINATIONS
☐ ATAXIA
☐ GROSS MOTOR CHANGE
☐ SLURRED SPEECH
☐ VERTIGO
COMMENTS/SEVERITY/FREQUENCY:

MUSCULOSKELETAL: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ ATAXIA
☐ PAIN
☐ DEFORMITY (DESCRIBE)
☐ PARAPLEGIC
☐ SWELLING
☐ STIFFNESS
☐ HEMIPLEGIC
COMMENTS/SEVERITY/FREQUENCY:

PAIN: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED

TYPE:
☐ ACUTE
☐ AT REST
☐ CONSTANT
☐ CHRONIC
☐ SPORADIC
☐ WITH MOVEMENT

QUALITY:
☐ ACHING
☐ THROBBING
☐ BURNING
☐ DULL
☐ SHARP
☐ PRESSURE
☐ SHOOTING

COMMENTS/SEVERITY/FREQUENCY:

MENTAL STATUS: (CHECK ALL THAT APPLY)
☐ NO PROBLEMS IDENTIFIED
☐ ALERT MOOD:
☐ ORIENTED: AFFECT:
☐ OTHER (SPECIFY):

COMMENTS/SEVERITY/FREQUENCY:

SECTION 6
NUTRITION IN PAST 60 DAYS

PRESENT HEIGHT:

CURRENT WEIGHT:

WEIGHT GAIN IN PAST 60 DAYS: ☐ YES ☐ NO
WEIGHT LOSS IN PAST 60 DAYS: ☐ YES ☐ NO
COMMENTS:

APPETITE:
☐ EXCELLENT
☐ GOOD
☐ FAIR
☐ POOR
CHANGES IN THE PAST 60 DAYS: ☐ YES ☐ NO
COMMENTS:

ACTIVITY LEVEL:
☐ VERY ACTIVE
☐ MODERATELY ACTIVE
☐ MILDLY ACTIVE
☐ MOSTLY SEDENTARY
CHANGES IN THE PAST 60 DAYS: ☐ YES ☐ NO
COMMENTS:

CLIENT NAME: **CHART NUMBER**:

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SECTION 6
NUTRITION IN PAST 60 DAYS (CONT'D)

NEW FOOD ALLERGIES:
LIST:

FOLLOWING SPECIAL DIET: ☐ YES ☐ NO
☐ MACROBIOTIC
☐ VEGETARIAN
☐ IMMUNE BOOSTING
☐ OTHER
COMMENTS:

PHYSIOLOGICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)

☐ CHEWING	☐ CONSTIPATION	☐ DRY MOUTH
☐ SWALLOWING	☐ DIARRHEA	☐ TASTE PERCEPTION
☐ NAUSEA	☐ ABDOMINAL CRAMPING/BLOATING	☐ APPETITE CHANGES
☐ VOMITING	☐ HEARTBURN/INDIGESTION	☐ OTHER (SPECIFY):

COMMENTS:

MEDICAL ISSUES AFFECTING NUTRITION: (CHECK ALL THAT APPLY)

☐ ULCER/STOMACH PROBLEMS	☐ MOUTH SORES/GUM INFECTIONS	☐ OTHER (SPECIFY):
☐ HEART DISEASE/HYPERTENSION	☐ FATIGUE	
☐ DIABETES	☐ FEVER	

COMMENTS:

PSYCHOSOCIAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

PHYSICAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

FINANCIAL ISSUES AFFECTING NUTRITION: ☐ YES ☐ NO
COMMENTS:

NUTRITIONAL SUPPLEMENTS: (CHECK ALL THAT APPLY)

☐ VITAMINS	☐ HERBS/OTHER	☐ OTHER (SPECIFY):
☐ MINERALS	☐ ENSURE/BOOST	

COMMENTS:

ALTERNATIVE NUTRITION:

☐ TPN	☐ LIPIDS	☐ TUBE FEEDING

COMMENTS:

OTHER BARRIERS TO ACHIEVING OPTIMAL NUTRITIONAL STATUS: ☐ YES ☐ NO
COMMENTS:

DOES CLIENT NEED ASSISTANCE WITH MEALS (MEALS ON WHEELS, ATTENDANT CARE, ETC.): ☐ YES ☐ NO
COMMENTS:

NUTRITIONAL EDUCATION PROVIDED: ☐ YES ☐ NO
COMMENTS:

NUTRITIONAL REFERRAL NEEDED: ☐ YES ☐ NO
COMMENTS:

NUTRITIONAL SUMMARY/PLAN:

CLIENT NAME: **CHART NUMBER**:

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SECTION 7
MEDICATION ADHERENCE IN PAST 60 DAYS

ANY CHANGES IN MEDICATION REGIMEN (HAART OR OTHER): ☐ YES ☐ NO
IF YES, REFER TO MEDICATION SHEET

CLIENT UNDERSTANDS MEDICATION REGIMEN: ☐ YES ☐ NO
COMMENTS:

CLIENT ADHERES TO MEDICATION REGIMEN: ☐ YES ☐ NO
COMMENTS:

CLIENT'S ABILITY TO TAKE MEDICATIONS (HAART OR OTHER):
DID THE CLIENT MISS ANY DOSES YESTERDAY? ☐ YES ☐NO
DID THE CLIENT MISS ANY DOSES THE DAY BEFORE YESTERDAY? ☐ YES ☐NO

☐ CLIENT IS ABLE TO INDEPENDENTLY TAKE CORRECT MEDICATION(S) & DOSE AT CORRECT TIMES
☐ CLIENT IS ABLE TO TAKE CORRECT MEDICATION(S) & DOSES AT CORRECT TIMES WITH SUPERVISION OR ASSISTANCE
☐ CLIENT IS UNABLE TO TAKE MEDICATION(S) UNLESS ADMINISTERED BY SOMEONE ELSE
☐ UNABLE TO ASSESS CLIENT'S ABILITY TO TAKE MEDICATIONS

COMMENTS:

ADHERENCE BARRIERS:
☐ MEDICATION REGIMEN IS TOO COMPLEX
☐ SCHEDULING PROBLEMS
☐ MENTAL STATUS CHANGES
☐ ALCOHOL/DRUG USE/ABUSE
☐ DEPRESSION
☐ MEDICATION SIDE EFFECTS
☐ LANGUAGE/CULTURAL BARRIERS
☐ DIFFICULTY SWALLOWING MEDICATION
☐ MISUNDERSTANDING REGARDING MEDICATION EFFECTIVENESS
☐ NO SOCIAL SUPPORT
☐ NEEDS ASSISTANCE WITH ADL'S
☐ PROBLEMS OBTAINING MEDICATION OR REFILLS
☐ CULTURAL BELIEFS
☐ LACK OF REFRIGERATION, SAFE STORAGE
☐ CURRENT SUBSTANCE USE
COMMENTS:

IS THE CLIENT EXPERIENCING ANY OF THE FOLLOWING MEDICATION SIDE EFFECTS:
☐ ANOREXIA ☐ DIARRHEA ☐ DIZZINESS ☐ FATIGUE ☐ RASH
☐ NEUROPATHY ☐ WEIGHT LOSS ☐ WEIGHT GAIN ☐ NAUSEA/VOMITING

HAS THE MEDICAL PROVIDER BEEN NOTIFIED: ☐ YES ☐NO DATE: TIME:
COMMENTS:

COMPLIMENTARY ALTERNATIVE THERAPIES:
☐ ACUPUNCTURE
☐ ACUPRESSURE
☐ BIOFEEDBACK
☐ HERBAL
☐ HOMEOPATHY
☐ HYPNOSIS
☐ MASSAGE
☐ OTHER:
COMMENTS:

IV ACCESS/NAME AND LOCATION:
☐ PICC LOCATION:
☐ PORT-A-CATH LOCATION:
☐ GROSHONG LOCATION:
☐ HICKMAN LOCATION:
INFUSION COMPANY:
COMMENTS:

CLIENT NAME: **CHART NUMBER**:

SECTION 8
RISK FACTORS FOR HIV TRANSMISSION

NEEDLE SHARING: ☐ YES ☐ NO COMMENTS:	**SEX WORK:** ☐ YES ☐ NO COMMENTS:
UNPROTECTED SEX WITH MEN: ☐ YES ☐ NO COMMENTS:	**UNPROTECTED SEX WITH WOMEN:** ☐ YES ☐ NO COMMENTS:
SEX WITH IDU: ☐ YES ☐ NO COMMENTS:	**SEX WITH HIV+ INDIVIDUAL:** ☐ YES ☐ NO COMMENTS:

DISCUSSION OF CURRENT HARM REDUCTION PRACTICES: ☐ YES ☐ NO
COMMENTS:

SECTION 9
RISK ASSESSMENT AND EXPLOITATION

WERE THERE ANY INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION OF THE CLIENT IN PAST 60 DAYS?
☐ YES ☐ NO
IF YES, TYPE OF ABUSE: ☐ PHYSICAL ☐ ISOLATION ☐ FINANCIAL ☐ ABANDONMENT ☐ SEXUAL ☐ VERBAL
☐ NEGLECT BY SELF OR OTHER ☐ EMOTIONAL
IDENTIFYING INSTANCE(S):
REPORT MADE TO: ☐ APS ☐ CPS ☐ LAW ENFORCEMENT ☐ LONG TERM CARE OMBUDSMAN
OUTCOME:
COMMENTS:

SECTION 10
SUMMARY/FOLLOW UP ON PREVIOUSLY IDENTIFIED CONCERNS

SECTION 11
PLAN/IDENTIFICATION OF POTENTIAL PROBLEMS OR CONCERNS

CLIENT NAME: **CHART NUMBER**:

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SECTION 12
DOCUMENTATION OF SERVICE PLAN REVIEW WITH CLIENT

☐ SERVICE PLAN WAS REVIEWED WITH CLIENT DURING THIS REASSESSMENT

COMMENTS:

SECTION 13
CERTIFICATION

MCWP ONLY: CLIENT MEETS THE MINIMUM NURSING FACILITY LEVEL OF CARE CRITERIA: ☐ YES ☐NO

CMP ONLY: CLIENT MEETS ELIGIBILITY REQUIREMENTS BASED ON THE FOLLOWING SYMPTOMS:

_____ _____

NURSE CASE MANAGER SIGNATURE/CREDENTIALS DATE

CLIENT NAME: **CHART NUMBER**:

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SECTION 1
IDENTIFYING INFORMATION

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

HIV STATUS/DATE OF DIAGNOSIS:	**MODE OF TRANSMISSION**:
DATE OF REASSESSMENT:	**LOCATION OF REASSESSMENT**:

RELATIONSHIP STATUS (IF CHANGED IN PAST 60 DAYS):

☐ MARRIED
☐ SINGLE
☐ DIVORCED
☐ WIDOWED
☐ DOMESTIC PARTNER
☐ SEPARATED
☐ SIGNIFICANT OTHER NAME:

PRIMARY MEDICAL PROVIDER:
ADDRESS:
PHONE:

EMERGENCY CONTACT (IF CHANGED IN PAST 60 DAYS):

PRIMARY:
NAME:
RELATIONSHIP:
PHONE:
AWARE OF STATUS: ☐ YES ☐ NO
OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO

SECONDARY:
NAME:
RELATIONSHIP:
PHONE:
AWARE OF STATUS: ☐ YES ☐ NO
OK TO LEAVE SPECIFIC MESSAGE? ☐ YES ☐ NO

WHAT OTHER AGENCIES ARE ASSISTING YOU?

CLIENT NAME:	**CHART NUMBER:**

SECTION 2
LEGAL INFORMATION IN PAST 60 DAYS

ARRESTS (IN PAST 60 DAYS): ☐ YES ☐ NO WHEN: WHERE: REASON:	**INCARCERATIONS:** ☐ YES ☐ NO WHEN: WHERE: REASON:
PAROLE: ☐ YES ☐ NO NAME: ADDRESS: PHONE: AWARE OF STATUS? ☐ YES ☐ NO	**PROBATION**: ☐ YES ☐ NO NAME: ADDRESS: PHONE: AWARE OF STATUS? ☐ YES ☐ NO
DPOA FOR HEALTHCARE COMPLETED: ☐ YES ☐ NO DECLINES: HEALTHCARE AGENT NAME: HEALTHCARE AGENT PHONE:	**DPOA FOR FINANCIAL COMPLETED:** ☐ YES ☐ NO DECLINES: FINANCIAL AGENT NAME: FINANCIAL AGENT PHONE:
WILL COMPLETED: ☐ YES ☐ NO COMMENTS:	**ATTORNEY:** ☐ YES ☐ NO NAME: ADDRESS: PHONE:
CONSERVATOR/GUARDIAN: ☐ YES ☐ NO NAME: ADDRESS: PHONE:	**REPRESENTATIVE PAYEE:** ☐ YES ☐ NO NAME: ADDRESS: PHONE:
CODE STATUS: DNR: ☐ YES ☐ NO FULL: ☐ YES ☐ NO COMMENTS:	**FUNERAL ARRANGEMENTS:** ☐ YES ☐ NO COMMENTS:
GUARDIAN OF MINOR CHILDREN: ☐ YES ☐ NO ☐ N/A NAME: ADDRESS: PHONE:	**PROTECTIVE SERVICES INVOLVED :** **ADULT:** ☐ YES ☐ NO **CHILD:** ☐ YES ☐ NO
DOES CLIENT NEED HELP WITH ANY LEGAL ISSUES? ☐ YES ☐ NO COMMENTS:	

SECTION 3
RISK ASSESSMENT AND MITIGATION IN PAST 60 DAYS

WERE THERE ANY INSTANCES OF ABUSE, NEGLECT, OR EXPLOITATION OF THE CLIENT IN PAST 60 DAYS?
☐ YES ☐ NO

IF YES, TYPE OF ABUSE:

☐ PHYSICAL	☐ ABANDONMENT
☐ ISOLATION	☐ SEXUAL
☐ FINANCIAL	☐ VERBAL
☐ NEGLECT BY SELF OR OTHER	☐ EMOTIONAL

IDENTIFYING INSTANCE(S):
REPORT MADE TO: ☐ APS ☐ CPS ☐ LAW ENFORCEMENT ☐ LONG TERM CARE OMBUDSMAN
OUTCOME:
COMMENTS:

CLIENT NAME:	**CHART NUMBER:**

SECTION 4
SOCIAL STATUS IF CHANGED IN PAST 60 DAYS

PRIMARY CAREGIVER (IF CHANGED):
NAME:
RELATIONSHIP:
AWARE OF STATUS: ☐ YES ☐ NO
PHONE:
IS IT OK TO LEAVE A MESSAGE? ☐ YES ☐ NO

SUPPORT SYSTEM (IF CHANGED):

FRIENDS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
NEIGHBORS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
GROUPS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO
ORGANIZATIONS:	☐ YES ☐ NO	AWARE OF STATUS: ☐ YES ☐ NO

COMMENTS:

LIVING ARRANGEMENTS/ENVIRONMENT (IF CHANGED):
NAME:
RELATIONSHIP:
AWARE OF STATUS: ☐ YES ☐ NO
ENVIRONMENTAL ISSUES:

DOES CLIENT HAVE PETS (IF CHANGED): ☐ YES ☐ NO
COMMENTS:

HOBBIES (IF CHANGED):

ADDITIONAL SUPPORT/REFERRAL NEEDED FOR CHILD CARE: ☐ YES ☐ NO
COMMENTS:

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SECTION 5
MENTAL HEALTH/EMOTIONAL STATUS

MENTAL HEALTH TREATMENT IN PAST 60 DAYS: INPATIENT: ☐ YES ☐ NO OUTPATIENT: ☐ YES ☐ NO MEDICATIONS: EVENTS: COMMENTS:	**CURRENT PSYCHIATRIC DIAGNOSIS:**
CURRENT PSYCHIATRIC MEDICATIONS:	**CHANGES IN ADJUSTMENT TO ILLNESS:**
NEW COPING STRATEGIES:	**CURRENT STRENGTHS:** **CURRENT WEAKNESSES:**
CURRENT THERAPIST: AWARE OF STATUS: ☐ YES ☐ NO	**CURRENT SUPPORT GROUP:** AWARE OF STATUS: ☐ YES ☐ NO
CURRENT PSYCHIATRIST: AWARE OF STATUS: ☐ YES ☐ NO	**RECENT DEPRESSION:** ☐ YES ☐ NO **COMMENTS:**
RECENT ANXIETY: ☐ YES ☐ NO **COMMENTS:**	**AIDS RELATED DEMENTIA:** ☐ YES ☐ NO **COMMENTS:**
DOES CLIENT NEED MENTAL HEALTH REFERRAL: ☐ YES ☐ NO COMMENTS:	

CLIENT NAME:	**CHART NUMBER:**

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SECTION 6
MENTAL STATUS EXAMINATION (MSE)

APPEARANCE:

GROOMING: ☐ NEAT/CLEAN ☐ DISHEVELED/DIRTY
HYGIENE: ☐ CLEAN ☐ MALODOROUS
AGE: ☐ LOOKS OLDER THAN AGE ☐ LOOKS YOUNGER THAN AGE
OTHER:

EYE CONTACT:

☐ APPROPRIATE
☐ MINIMAL ERRATIC
☐ NONE

BEHAVIOR/MOTOR ACTIVITY:

☐ RELAXED
☐ RESTLESS
☐ PACING
☐ SEDATE
☐ THREATENING
☐ CATATONIC
☐ POSTURING
☐ TREMORS/TICS
☐ APPROPRIATE TO SITUATION
☐ INAPPROPRIATE TO SITUATION
☐ OTHER:

ATTITUDE:

☐ CALM
☐ PLEASANT
☐ COOPERATIVE
☐ RESISTANT
☐ DEFENSIVE
☐ EVASIVE
☐ GUARDED
☐ SUSPICIOUS
☐ DEMANDING
☐ MANIPULATIVE
☐ WITHDRAWN
☐ HOSTILE
☐ OTHER

SPEECH:

☐ SLOW
☐ RAPID
☐ CLEAR
☐ MUMBLED
☐ SLURRED
☐ SOFT
☐ LOUD
☐ INCREASED QUANTITY
☐ DECREASED QUANTITY
☐ OTHER:

MOOD:

☐ NORMAL
☐ EUPHORIC
☐ ELEVATED
☐ DEPRESSED
☐ ANGRY
☐ IRRITABLE
☐ AGITATED
☐ ANXIOUS
☐ APATHETIC
☐ PLEASANT
☐ UNPLEASANT
☐ NEUTRAL
☐ FEARFUL
☐ ELATED
☐ SAD
☐ OTHER:

AFFECT:

☐ BROAD
☐ RESTRICTED
☐ BLUNTED
☐ FLAT
☐ LABILE
☐ APPROPRIATE TO SITUATION
☐ INAPPROPRIATE TO SITUATION
☐ OTHER:

ORIENTATION:

☐ PERSON
☐ PLACE
☐ TIME
☐ SITUATION

ATTENTION:

☐ NORMAL
☐ HYPER
☐ VIGILANT
☐ DISTRACTIBLE

CONCENTRATION:

☐ GOOD
☐ FAIR
☐ POOR

MEMORY:

IMMEDIATE: ☐ GOOD ☐ FAIR ☐ POOR
RECENT: ☐ GOOD ☐ FAIR ☐ POOR
REMOTE: ☐ GOOD ☐ FAIR ☐ POOR

THOUGHT CONTENT:

☐ IDEAS OF REFERENCE
☐ GRANDIOSITY
☐ PHOBIAS
☐ OBSESSIONS/COMPULSIONS
☐ DELUSIONS
☐ DEPERSONALIZATION
☐ SUICIDAL IDEATIONS
☐ HOMICIDAL IDEATIONS
☐ HYPOCHONDRIACHAL
☐ RELIGIOUSLY PREOCCUPIED
☐ SEXUALLY PREOCCUPIED
☐ OTHER:

CLIENT NAME: **CHART NUMBER:**

SECTION 6
MENTAL STATUS EXAMINATION (MSE) (CONT'D)

THOUGHT PROCESS:

- ☐ NORMAL
- ☐ SLOW/INHIBITED
- ☐ RAPID/RACING
- ☐ CIRCUMSTANTIAL
- ☐ TANGENTIAL
- ☐ BLOCKING
- ☐ FLIGHT OF IDEAS
- ☐ PARANOID
- ☐ LOOSE ASSOCIATIONS
- ☐ OTHER:

PERCEPTION:

☐ HALLUCINATIONS:

- ☐ AUDITORY
- ☐ VISUAL
- ☐ OLFACTORY
- ☐ GUSTATORY
- ☐ TACTILE
- ☐ SOMATIC

JUDGEMENT:

- ☐ GOOD
- ☐ FAIR
- ☐ POOR

INSIGHT:

- ☐ GOOD
- ☐ FAIR
- ☐ POOR

IMPULSE CONTROL:

- ☐ GOOD
- ☐ FAIR
- ☐ POOR

CLIENT NAME: **CHART NUMBER:**

SECTION 7
SUBSTANCE USE/ABUSE IN PAST 60 DAYS

ALCOHOL: ☐ YES ☐ NO COMMENTS:	**CANNABIS:** ☐ YES ☐ NO COMMENTS:
HEROIN: ☐ YES ☐ NO COMMENTS:	**CRACK/COCAINE:** ☐ YES ☐ NO COMMENTS:
CRANK/METH/SPEED: ☐ YES ☐ NO COMMENTS:	**PRESCRIPTIONS:** ☐ YES ☐ NO COMMENTS:
CAFFEINE: ☐ YES ☐ NO COMMENTS:	**NICOTINE:** ☐ YES ☐ NO COMMENTS:
INHALANTS: ☐ YES ☐ NO COMMENTS:	**GHB/ECSTACY/KETAMINE:** ☐ YES ☐ NO COMMENTS:
HALLUCINOGENS: ☐ YES ☐ NO (LSD, MESCALINE, PCP) COMMENTS:	**OTHER:** ☐ YES ☐ NO COMMENTS:

IN NEED OF DETOX OR TREATMENT PROGRAM: ☐ YES ☐ NO COMMENTS:

REFERRAL TO AA, OUTPATIENT: ☐ YES ☐ NO COMMENTS:

SECTION 8
RISK FACTORS IN PAST 60 DAYS

NEEDLE SHARING: ☐ YES ☐ NO COMMENTS:	**SEX WORK:** ☐ YES ☐ NO COMMENTS:
UNPROTECTED SEX WITH WOMEN: ☐ YES ☐ NO COMMENTS:	**UNPROTECTED SEX WITH MEN:** ☐ YES ☐ NO COMMENTS:
SEX WITH HIV+ INDIVIDUAL: ☐ YES ☐ NO COMMENTS:	**SEX WITH IDU:** ☐ YES ☐ NO COMMENTS:

DISCUSSION OF CURRENT HARM REDUCTION PRACTICES: ☐ YES ☐ NO
COMMENTS:

SECTION 9
FOOD/HOUSING/TRANSPORTATION

CLIENT CURRENTLY RECEIVES:

FOOD:	**HOUSING:**	**TRANSPORTATION:**
☐ FOOD BANK	☐ HOPWA	☐ BUS
☐ FOOD VOUCHERS	☐ SECTION 8	☐ TAXI
☐ MEALS ON WHEELS	☐ OTHER	☐ OTHER
☐ OTHER		

DOES CLIENT NEED TRANSPORTATION, FOOD, HOUSING ASSISTANCE: ☐ YES ☐ NO
COMMENTS:

CLIENT NAME:	**CHART NUMBER:**

AIDS CMP/MCWP
Psychosocial
Reassessment

SECTION 10
PRACTICAL SUPPORT

ACTIVITIES OF DAILY LIVING:

	HOW ARE NEEDS MET/BY WHOM:	ASSISTANCE REQUIRED:
MEALS		SEE SECTION 8
TRANSPORTATION		SEE SECTION 8
PERSONAL CARE		☐ YES ☐ NO
HOUSEKEEPING		☐ YES ☐ NO
MOBILITY		☐ YES ☐ NO
MEDICATIONS		☐ YES ☐ NO
LAUNDRY		☐ YES ☐ NO
SHOPPING		☐ YES ☐ NO
APPOINTMENTS		☐ YES ☐ NO

ATTENDANT CARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

IHSS: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

HOSPICE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

LIFELINE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

CHILDCARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

ADULT DAY CARE: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

MEDICATION MANAGEMENT: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

OTHER: ☐ RECEIVING ☐ NEEDED ☐ REFERRED ☐ N/A
COMMENTS:

CLIENT NAME: **CHART NUMBER:**

AIDS CMP/MCWP
Psychosocial
Reassessment

SECTION 11
FINANCIAL REASSESSMENT

CURRENT EMPLOYMENT/OCCUPATION STATUS:
AWARE OF STATUS: ☐ YES ☐ NO
MAY WE LEAVE MESSAGE: ☐ YES ☐ NO
COMMENTS:

INCOME SOURCE:

☐ SSI $	☐ TANF $	☐ WIC $
☐ SSDI $	☐ UNEMPLOYMENT $	☐ SECTION 8 $
☐ GA $	☐ FOOD STAMPS $	☐ OTHER $

MONTHLY EXPENSES:

HOUSING (RENT & MORTGAGE):	$	CABLE	$
UTILITIES (GAS & ELECTRIC):	$	CLOTHING:	$
TELEPHONE:	$	ENTERTAINMENT:	$
FOOD:	$	TOBACCO:	$
TRANSPORTATION:	$	ALCOHOL:	$
MEDICAL:	$	MISCELLANEOUS/OTHER:	$
AUTO (LOAN & INSURANCE)	$		

RECEIVING BENEFITS: ☐ YES ☐ NO (REFER TO RESOURCE EVALUATION FORM)

NET INCOME: INCOME $ - EXPENSES $ = NET INCOME $
COMMENTS:

DOES CLIENT NEED FINANCIAL COUNSELING OR ASSISTANCE WITH BENEFITS: ☐ YES ☐ NO

CLIENT NAME: **CHART NUMBER:**

SECTION 12
SUMMARY/FOLLOW UP ON PREVIOUSLY IDENTIFIED CONCERNS

SECTION 13
PLAN/IDENTIFICATION OF POTENTIAL PROBLEMS OR CONCERNS

SECTION 14
DOCUMENTATION OF SERVICE PLAN REVIEW WITH CLIENT

☐ SERVICE PLAN WAS REVIEWED WITH CLIENT DURING THIS REASSESSMENT
COMMENTS:

SECTION 15
SIGNATURE

_____	_____	_____
SOCIAL WORK CASE MANAGER	CREDENTIALS	DATE

CLIENT NAME:	**CHART NUMBER:**

AIDS CMP/MCWP
Cost Avoidance

SECTION 1
NARRATIVE NOTES

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

DATE:	SERVICE:	Include documentation of any attempts at accessing other payer sources prior to using CMP/MCWP funds. Please refer to the *Cost Avoidance Instructions in Section XIII, Pages 2-5* for details on when to document cost avoidance activities and required elements to be documented.	INITIALS

SECTION 2
SIGNATURE

CASE MANAGER :	CREDENTIALS:	INITIALS:	DATE:

CLIENT NAME: **CHART NUMBER:**

AIDS CMP/MCWP
Interdisciplinary Team Case Conference (IDTCC)

SECTION 1
SERVICE PLAN

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

SERVICE PLAN REVIEWED: (OPTIONAL) ☐ YES ☐ NO	**CHANGES:** ☐ YES, SEE SERVICE PLAN ☐ NO

SECTION 2
REVIEW OF CLIENT'S CURRENT STATUS, CHANGES, SERVICE PLAN

MEDICAL: ☐ YES ☐ NO COMMENTS:	**PSYCHOSOCIAL:** ☐ YES ☐ NO COMMENTS:
HOUSING: ☐ YES ☐ NO COMMENTS:	**FINANCIAL:** ☐ YES ☐ NO COMMENTS:

SECTION 3
TRANSITION PLANNING/GOALS

SECTION 4
COMMENTS

SECTION 5
PARTICIPANTS (INITIALS/CREDENTIALS)

☐ NURSE CASE MANAGER	_____/_____	_____/_____	_____/_____	_____/_____
	_____/_____	_____/_____	_____/_____	_____/_____
	_____/_____	_____/_____	_____/_____	_____/_____
☐ SOCIAL WORK CASE MANAGER	_____/_____	_____/_____	_____/_____	_____/_____
	_____/_____	_____/_____	_____/_____	_____/_____
	_____/_____	_____/_____	_____/_____	_____/_____
☐ OTHER SERVICE PROVIDERS: LIST:	_____/_____	_____/_____	_____/_____	_____/_____
	_____/_____	_____/_____	_____/_____	_____/_____

☐ PROJECT DIRECTOR _____/_____
☐ CLIENT/CLIENT LEGAL REPRESENTATIVE _____/_____
☐ ATTENDING PHYSICIAN _____/_____
☐ PRIMARY CARE PRACTITIONER _____/_____

SECTION 6
SIGNATURE

_____ _____ _____
CASE MANAGER CREDENTIALS: DATE:

CLIENT NAME: **CHART NUMBER:**

Form	Number	Revision Date	Type
Comprehensive Service Plan	CMP/MCWP 14	4/05	Sample
Service Plan Attachment A	CMP/MCWP 14 Attachment	4/05	Sample
Standardized Comprehensive Service Plan	CMP/MCWP 14 (a)	3/06	Sample

Mandatory Forms: must be used "as is"; no changes may be made to these forms.
Sample Forms: may be revised to meet an individual contractor's needs but must contain all of the elements within the forms. Forms can be identified as either sample or mandatory by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (S) for sample forms or (M) for mandatory forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

AIDS CASE MANAGEMENT PROGRAM/AIDS MEDI-CAL WAIVER PROGRAM

COMPREHENSIVE SERVICE PLAN

☐ CMP CLIENT ☐ MCWP CLIENT						EVALUATION				
LONG TERM GOAL(S):						DATE/INITIALS/CODE				
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOAL(S)**	**INTERVENTION(S)** *SERVICE / QUANTITY / FREQUENCY / DURATION / TYPE OF SERVICE*	**PSC**	**START OF SERVICE**					

RN Case Manager: Signature / Initials

/

/

/

SW Case Manager: Signature / Initials

/

/

/

M.D. sent copy/notified of contents of initial plan? YES Date:

Initial Service Plan Discussed with Client? YES Date:

Payment Source Codes

Medi-Cal Waiver (MCW)	W
Private/3rd Party	1
CMP	2
Medi-Cal	3
Medicare	4
Multiple (see progress notes)	5
Other (see progress notes)	6
Care Title I/II	7
HOPWA	8

Evaluation Codes

Referral Initiated	A
Referral Refused	B
Services Refused/Cont. to Adv.	C
Services Initiated	D
Services Continued	E
Services Continued w/ Changes	F
Services Discontinued	G
Services Not Delivered	H
Goal Achieved	I

CLIENT NAME: **CHART NUMBER**:

						Evaluation Review, and/or changes DATE/INITIALS/CODE				
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOAL(S)**	**INTERVENTION(S)** ***SERVICE / QUANTITY / FREQUENCY / DURATION / TYPE OF SERVICE***	**PSC**	**START OF SERVICE**					

CLIENT NAME: **CHART NUMBER**:

Comprehensive Service Plan
Attachment A

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

Date	Intervention(s) Service/Quantity/Frequency/Duration/Type of Provider	Start of Service	Contact Person	Initials

NURSE CASE MANAGER/SOCIAL WORK CARE MANAGER SIGNATURE	INITIALS:	DATE:

CLIENT NAME: **CHART NUMBER**:

STANDARDIZED COMPREHENSIVE SERVICE PLAN

☐ **CMP CLIENT** ☐ **MCWP CLIENT**

DATE/INITIALS/CODE

LONG TERM GOAL(S):

1. Client to remain at home in lieu of institutionalization
2. Client to receive assistance in accessing and coordinating all necessary community resources.
3. Client knowledgeable re: illness, disease process, medications, treatments, and timely reporting of signs & symptoms
4. Client's legal documents completed

DATE PROBLEM IDENTIFIED	PROBLEM/NEED	GOAL(S)	INTERVENTION(S) SERVICE/QUANTITY/FREQUENCY/ DURATION/TYPE OF SERVICE	P S C	START OF SERVICE	DATE/INITIALS/CODE
	Compromised Immune Status	• Maintain Optimal Health Status. • Advocate for self • Report s/s of OIs to MD	☐ See Primary Medical Provider; At Least Quarterly & PRN for one year			
			☐ RN/SW Case Management; Reassessment At Least q 60 Days and Contact Between Reassessments as Deemed Appropriate by Case Mangers			
	Specialized Medical Care (e.g. specialty care for CMV, TB, DM, etc.) R/T: _____ – _____ – _____ –	☐ Will Receive Specialty Care as Indicated.	☐ Specialty Care by Dr: _____ Quarterly & PRN for 6 months			
			☐ Specialty Care by Dr: _____ Quarterly & PRN for 6 months			
			☐ Specialty Care by Dr: _____ Quarterly & PRN for 6 months			
			☐ Other: _____; q _____ for 6 mos			
	Dental Care	☐ Access to Regular Dental Care.	☐ Private Dentist; q 6 Months & PRN for one year			
			☐ Other: _____; q _____ for ____			

RN Case Manager: Signature / Initials

/

/

/

SW Case Manager: Signature / Initials

/

/

/

M.D. sent copy/notified of contents of initial plan? YES Date:

Initial Service Plan Discussed with Client? YES

Payment Source Codes

Medi-Cal Waiver (MCW)	W
Private/3rd Party	1
CMP	2
Medi-Cal	3
Medicare	4
Multiple (see progress notes)	5
Other (see progress notes)	6
Care Title I/II	7
HOPWA	8

Evaluation Codes

Referral Initiated	A
Referral Refused	B
Services Refused/Cont. to Adv.	C
Services Initiated	D
Services Continued	E
Services Continued w/ Changes	F
Services Discontinued	G
Services Not Delivered	H
Goal Achieved	I

CLIENT NAME: **CHART NUMBER**:

						DATE/INITIALS/EVAL CODE					
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**						
	Weight Maintenance	☐ Have Access to Adequate Nutritional Resources. ☐ Maintain Optimum Weight for Height	☐ Meals on Wheels--Hot Meals; Daily for 60 days								
			☐ _____ Food Bank; q _____ for 60 days								
			☐ Nutritional Supplements; See Attachment A								
			☐ Food Vouchers $_____; q _____ for 6 mos								
			☐ Other: _____; q _____ for 6 mos								
			☐ Ongoing assessment by NCM								
	Requires Assistance with Activities of Daily Living/Self-Care Deficit	☐ Domestic & Personal Care Needs Will Be Met.	☐ Attendant Care (See Attachment A)								
			☐ IHSS: _____ Hours; q Month for 60 days								
			☐ Volunteer, ☐ Family Member, ☐ S/O to Provide Care; ____hrs, q _____ for 60 days								
			☐ Other: _____; q _____ for 60 days								
			☐ Ongoing assessment by NCM								
	Complicated Medication Regime	☐ Will Have Access to Prescribed Medications ☐ Adherence to Medication Regimen.	☐ Medication Adherence Education/Monitoring by _____; q 30-60 days for one year								
			☐ Pharmacy:_____								
			☐ Weekly Delivery by Medication Service (See Attachment A)								
			☐ ADAP Services q. month (Recertification q year due_____)								

CLIENT NAME: **CHART NUMBER**:

			☐ Other: _____; q _____								
						DATE/INITIALS/EVAL CODE					
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**						
	Mobility	☐ Achievement of Maximum Safe Mobility within Physical Limitations	☐ Durable Medical Equipment Provided (See Attachment A)								
			☐ PT; _____ Hours/Week (See Attachment A)								
			☐ OT, _____ Hours/Week (See Attachment A)								
			☐ Alterations Made to Living Space (See Attachment A)								
			☐ Other: _____; q _____ for _____								
			☐ Ongoing assessment by NCM								
	Skilled Nursing Needs	☐ Skilled Nursing Needs To Be Met per MD or RNCM Orders.	☐ Skilled Nursing Visit per orders (See Attachment A)								
			☐ In Home Hospice (See Attachment A)								
			☐ Residential Hospice (See Attachment A)								
			☐ SN Facility (See Attachment A)								
			☐ Other: _____; q _____ for _____								
			☐ Ongoing assessment by NCM								
	Pain Management	☐ Access to Assistance for Pain Control. ☐ Pain Level will Decrease	☐ Pain Management Clinic per MD orders (See Attachment A)								
			☐ Acupuncture / Therapeutic Massage (circle one or both) (See Attachment A)								
			☐ PT; _____ Hours per Week (See Attachment A)								

CLIENT NAME: **CHART NUMBER**:

			☐ OT; _____ Hours per Week (See Attachment A)									
			☐ Other: _____; q _____ for _____									
			☐ Ongoing assessment by NCM									
						DATE/INITIALS/EVAL CODE						
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**							
	Potential Spread of HIV	☐ Reduce risk of disease transmission	☐ Gloves									
			☐ Probe Covers									
			☐ Condoms									
			☐ Sharps									
			☐ Partner Notification (See Attachment A)									
			☐ Ongoing assessment by NCM/SWCM									
	Immunizations	☐ Will obtain Immunizations PRN	☐ PPD Date Last Test:_____									
			☐ Flu Date Last Immun:_____									
			☐ Hep B Date Immun:_____ ☐ Series Complete ☐ Booster Given									
			☐ Pneumonia Date Immun:_____									
			☐ Other:_____ Date Immun:_____									
			☐ Ongoing assessment by NCM									
	Substance Abuse	☐ Will Reduce Risk Associated with Substance Use.	☐ Inpatient Tx (See Attachment A)									
			☐ Group Home (See Attachment A)									
			☐ Outpatient Tx (See Attachment A)									
			☐ 12 Step Groups _____; q week for 60 days									

CLIENT NAME: **CHART NUMBER**:

			☐ Detox (See Attachment A)									
			☐ RN/SWCM Educate/Encourage Access to Tx/ Recovery Resources q 30-60 Days and PRN for one year									
			☐ Other: _____; q _____ for _____									
												DATE/INITIALS/EVAL CODE
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**							
	Assistance with Pet Care	☐ Decrease Risk of Infections R/T Pet Care ☐ Assistance with Pet Adoption-Out ☐ Pet will remain in home	☐ Family/Neighbor to provide pet care; _____ q_____and PRN for _____									
			☐ Volunteer; _____q_____and PRN for _____									
			☐ Animal Rescue/Adoption Service Initial Contact and PRN (one time only)									
			☐ Other: _____; q _____ for _____									
	Mental Health	☐ Will Maintain Optimum Mental Health.	☐ Subcontracted Therapist; ___Sessions q Week ☐ LCSW ☐ MFCC ☐ PhD ☐ PsyD for _____									
			☐ Psychiatrist; q _____ for _____									
			☐ Other Outpatient Psychotherapy; ____Sessions q Week: ☐ LCSW ☐ MFCC ☐ PhD ☐ PsyD (See Attachment A)									
			☐ Support Group; _____q _____for _____									
			☐ Buddy Program for 6 months									
			☐ Other: _____; q _____ for _____									
			☐ Ongoing assessment by SWCM									
	Transportation	☐ Will Access Non-Emergency	☐ One Bus Pass; q Month for 6 months									

CLIENT NAME: **CHART NUMBER**:

			☐ Taxi Voucher NTE $_____ q _____ for 60days									
			☐ Other: _____; q _____ for _____									
			☐ Ongoing assessment by NCM/SWCM									
						DATE/INITIALS/EVAL CODE						
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**							
	Housing	☐ Will Remain in Safe & Affordable Housing.	☐ Section 8 _____ q month for one year									
			☐ HOPWA grant $_____ q _____ for 6 mos									
			☐ Residential/assisted living, at: _____ for 6 mos									
			☐ Motel Voucher:_____ Days (up to _____ Days)									
			☐ Other: _____; q _____ for _____									
			☐ Ongoing assessment by NCM/SWCM									
	Legal	☐ Will Obtain Information, Referral, and/or Advocacy to Complete Legal Documents ☐ Will Resolve Outstanding Legal Issues ☐ Will Resolve Immigration Issues	☐ SWCM to provide info/assistance in completing Legal Documents q 30-60 Days and PRN (See Reassessments/Progress Notes) for one year									
			☐ Legal Referral Panel; (See Attachment A)									
			☐ Private Attorney_____ (See Attachment A)									
			☐ Other: _____: q _____ for _____									
			☐ Ongoing assessment by SWCM									
	Benefits	☐ Will Access Public/Private Benefits per Eligibility.	☐ Medi-Cal									
			☐ Medicare									
			☐ CMSP									
			☐ Private Insurance (See Resource Evaluation)									

CLIENT NAME: **CHART NUMBER**:

			☐ SSDI								
			☐ SSI								
			☐ Financial counseling								
			☐ Other:_____								
			☐ Ongoing assessment by SWCM								
											DATE/INITIALS/EVAL CODE
DATE PROBLEM IDENTIFIED	**PROBLEM/NEED**	**GOALS**	**INTERVENTION(S) SERVICE /QUANTITY/ FREQUENCY / DURATION / TYPE OF SERVICE**	**PSC**	**START OF SERVICE**						
	Risk Assessment and Mitigation	• Decrease Harm or Potential for Harm to Client • Ensure Client's Basic Safety and Well-being • Promote a Positive Quality of Life for All Persons	☐ APS Report								
			☐ CPS Report								
			☐ Law Enforcement Report								
			☐ Long Term Care Ombudsman Report								
			☐ Other:_____								
			☐ Ongoing Assessment by NCM and/or SWCM								

CLIENT NAME: **CHART NUMBER**:

Form	Number	Revision Date	Type
Quality Improvement/Quality Management (QI/QM) Guidelines	CMP/MCWP 15	3/06	Guidelines

Mandatory Forms: must be used "as is"; no changes may be made to these forms.
Sample Forms: may be revised to meet an individual contractor's needs but must contain all of the elements within the forms. Forms can be identified as either sample or mandatory by locating the form number/revision date in the lower left corner of each document. Following the revision date will be an (S) for sample forms or (M) for mandatory forms. Forms may also be considered guidelines, identified by a (G) in the lower left corner of the document.

Quality Improvement /Quality Management Guidelines

The following Quality Improvement/Quality Management (QI/QM) guidelines were developed with the assistance of Statewide AIDS Project Directors, Nurse Case Managers, and Social Work Case Managers. The purpose of these guidelines is to assure that every CMP and MCWP provides coordinated quality care in a cost-effective and culturally sensitive manner. The QI/QM guidelines should be used to develop each project's individual QI/QM Plan. The information obtained from some of the QI/QM activities provides project staff with information they can utilize to evaluate and improve their programs.

The client medical record review guidelines have a standard of compliance set at one hundred percent (100%). This compliance standard was established at this level because these are program requirements. We recognize that projects may not find this standard an immediate realistic goal. Therefore, we recommend that projects evaluate their current baseline compliance and establish incremental threshold goals with the understanding that they are working toward complete compliance.

The QI/QM Plan is to be submitted to OA annually, by July 31 of each fiscal year. The QI/QM summaries (and corrective action plans, if needed) are to be submitted with the semi-annual progress reports. Even though they are only reported semi-annually, QI/QM activities must be conducted on an ongoing basis during the reporting period.

QUALITY IMPROVEMENT/QUALITY MANAGEMENT (QI/QM) GUIDELINES

REQUIREMENT 1 **Case Management Program (Written)** **Policies & Procedures** **(P & P's)**	
Indicators	**Standards**
1. Waiting list 2. Food, housing, transportation, and utilities 3. Client grievance 4. Enrollment/ Disenrollment, denial of services 5. Cost avoidance 6. Criteria for admission and services to clients in a residential facility 7. Retention and confidentiality of client records 8. Continuity of case management services during expected and unexpected absence of the case management staff 9. Tuberculosis screening requirements 10. Risk Assessment and Mitigation	Projects must develop policies and procedures for all the required P & P's listed in the indicator column. The P & Ps must be reviewed and approved by the Department's assigned HPA. Once HPA approval has been obtained, the PD is required to: 1. Notify and fax or send his/her assigned HPA any significant revisions made to the required P& P's *within 30 calendar days* of the revision, for approval 2. Annually review, and update if necessary, the required P & P's.

REQUIREMENT 2 **Outreach Plan** Outreach to institutionalized population(s) and those disproportionately affected by HIV/AIDS either by incidence or mortality	
Indicators	**Standards**
The plan at a minimum contains: identification of target population(s), linkages with community resources and agencies for purposes of outreach and referrals; and a description of planned outreach activities, strategies, and materials.	1. A brief concise summary addressing the minimum outreach elements should be kept on file at the project. The PD should: a. annually review the plan, and update it as necessary b. notify his/her assigned HPA of any significant changes made to the plan
Outreach activities	2. Outreach activities target appropriate community and cultural groups. 3. Evidence of Project outreach activities a. Description of outreach activities reported on PR b. Referrals and outreach with community resources, agencies and institutions. c. Literacy/language appropriate brochures or flyers targeting cultural groups and other at-risk populations are accessible to clients.
Client linguistic/cultural needs	4. Project demonstrates attempts to meet linguistic/cultural needs of monolingual clients. (i.e. bilingual staff recruited, interpreter services available, written information in targeted cultural group language available at the project in client accessible areas.)

REQUIREMENT 3
Client Medical Record Review

All items to be included in client record review conducted by QI/QM committee annually.
(quarterly for indicators found to have a 75% or less compliance rating)

Committee may assign one or more of its members to conduct the review.

For each NCM and each SWCM, select records to review. Include any waiver client records that have exceeded the annual capitation rate in the annual review.

A *minimum* of six client records per project site must be reviewed annually.

Indicators	Standards
1. Initial Nursing and Psychosocial Assessment	1. 100% of records contain a NCM and SWCM initial assessment of all required components. NCM minimum initial assessment components listed in JACMP. SWCM initial assessment must be performed within 15 days of enrollment. NCM initial assessment must be performed on the date of or within 15 days prior to enrollment. Includes CFA, and for MCWP, NFLOC certification.
2. Initial contact with clients	2. 100% of records contain initial client contact by agency staff within 5 days of referral.
3. M.D./Primary Care Practitioner signed diagnosis certification	3. 100% of records contain MD/Primary Care Practitioner signed certification of client diagnosis, *within 45 days* of enrollment. For waiver clients, this document must be received prior to billing for services.
4. Client insurance/resource evaluation	4. 100% of records contain insurance eligibility and resource evaluation determined prior to enrollment and at least every 60 days. MCWP charts indicate verification of Medi-Cal status *prior* to enrollment and at the beginning of *each* month thereafter.
5. SWCM/NCM face-to-face reassessment every 60 days	5. 100% of records contain: a. Documented <u>*comprehensive*</u> face-to-face reassessment at least every 60 days by NCM and SWCM. b. Problems identified and documented by the SWCM/NCM are followed up and attempts are made to link to appropriate interventions until resolution or documented client refusal for further intervention(s).
6. Comprehensive Service Plan (CSP)/ IDTCase Conference	6. 100% of records contain: a. A CSP individualized to reflect service provision consistent with NCM and SWCM documentation of client need. b. Documentation of client review and approval of CSP within 60 days of enrollment indicated by client signature on CSP *or* NCM/SWCM documentation of client approval in client record. c. Documentation of IDT case conference and identification of conference participants at least every 60 days. d. Documentation of SWCM and NCM CSP review at least every 60 days and documentation of service change(s) or continuation consistent with NCM/SWCM documentation of client needs.
7. Facilitating access to medical care	7. 100% of records document case manager interventions to facilitate access to routine medical services, and specialty care when needed.
8. Cost avoidance	8. 100% of records contain documented evidence of cost avoidance activities prior to using CMP/MCWP funds for services.
9. Client informed consent	9. 100% of records contain client signed informed consent to participate on or within 15 days prior to the day of enrollment.
10. Client authorization for release of confidential information	10. 100% of records contain client signed authorization related to release of confidential information on or within 15 days prior to the day of enrollment.

REQUIREMENT 3 Client Medical Record Review (Cont'd)	
Indicators	**Standards**
11. Clients rights and responsibilities	11. 100% of records contain: a. Client signed acknowledgement of receipt of client's rights and responsibilities dated on or within 15 days prior to the date of enrollment.
Grievance procedure	b. Client signed acknowledgement of receipt of grievance policy and procedure dated on or within 15 days prior to the day of enrollment. Waiver clients receive information related to Notice of Action and rights for a State Fair Hearing.
12. Disenrollment criteria	12. 100% of records contain: a. Client signed acknowledgement of receipt of disenrollment criteria on or within 15 days prior to the date of enrollment. b. Waiver client's receipt of NOA and right to State Fair Hearing as required in the Inpatient/Outpatient Medi-Cal Manual.

REQUIREMENT 4 Quality Improvement/ Quality Management (QI/QM) Plan	
Indicators	**Standards**
1. QI/QM plan describes the project monitoring in terms of what, who, how, how often, and lists expected standards. *Minimum* required elements of the plan include:	1. Written QI/ QM Plan includes all indicators and the plan is annually reviewed by PD, and revised if indicated as required by HPA.
a. Client record review	a. Client record review conducted annually. See Client Medical Record Review section for a list of the required record review indicators.
b. Client satisfaction survey	b. Client satisfaction survey conducted annually. All enrolled clients should be surveyed.
c. Grievance and disenrollment, monitoring	c. All grievances and disenrollment monitoring conducted on an ongoing basis. Log(s) to be maintained that document the reason for disenrollment and or grievance, client and project actions (including information related to the timelines of the actions), and resolution
d. Risk assessment and mitigation	d. All instances of abuse, neglect, or exploitation are appropriately reported. Risk assessment and mitigation is documented in assessments, reassessments, comprehensive service plan, and progress notes.
2. QI/QM committee	2. Mandatory members are: The PD (who is the designated QI/QM coordinator), and representatives from the core case management team. Representation from both NCM *and* SWCM staff is required. PD may appoint a qualified staff member to act in his/her place but must have a policy/procedure depicting how QI/QM meeting activities, client survey and client record results, and how recommendations for corrective action(s) are communicated to PD for PD approval and oversight.
3. QI/QM meetings	3. QI/QM committee to meet quarterly at a minimum. Client record review results, client satisfaction survey, and findings related to disenrollment/grievances are analyzed for patterns or trends, appropriateness and timeliness of action(s). Committee recommends and develops corrective action plan(s) when appropriate. Summary of minutes of meetings must be kept on file at the project.
4. Corrective action	4. Corrective action plan(s) implemented for substandard indicators and identified problems. Plan(s) use a "systems" approach to address problems and issues. Committee follows up to assess efficacy of the action plan.
5. Semi-Annual Progress Report (PR)	5. Provide a summary of the results of QI/QM activities, recommendations, and corrective action(s) taken to be submitted with the PR. At a minimum, the summary should include annual report on indicators 1 a., 1 b., 1c.

REQUIREMENT 5 Provider Education	
Indicators	**Standards**
Staff education is current: a. case management practices and issues e. HIV/AIDS issues	1. PD shall have on file for all core NCM and SWCM staff members at the project, evidence of NCM/SWCM attendance at a minimum of a) one (1) training annually related to current HIV/AIDS issues and trends *and* b) one (1) training on current case management practices and issues. A training that combines both case management and HIV/AIDS update is acceptable. NCM/SWCM attendance at the statewide Department conference meets this requirement. Case management practices/issues can include topics such as team building, client advocacy, cultural and ethnic diversity, etc.
2. Staff member credentials	2. PD has a system in place to provide oversight/monitor current status of NCM/SWCM and sub-contracted staff member credentials and qualifications

REQUIREMENT 6 Coordination and Continuity of Care	
Indicators	**Standards**
Coordination of service	1. There is evidence of coordination of services between the project and other community AIDS service organizations. Example may include referral system between Title II and or EIP and the CMP/MCWP, and other community service organizations.
Communication with other AIDS service organizations in the community	2. There is evidence of periodic communication between the project and other community AIDS service organizations. Examples may include: PD participation in Title II consortia meetings, meetings with the PD of the EIP, etc.

REQUIREMENT 7 Monthly Data Submission	
Indicators	**Standards**
1. Timely data	1. Monthly data reports are to be sent to the Department 30 days following the end of the reporting period per the contract.
2. Accurate data	2. Data sent to the Department with all required information, utilizing the required format.
3. Data in correct format community	